UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

Colorado School of Mines

2025-2026

This Certificate of Coverage is Part of Policy # 2025-4059-1

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.

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.

Directory

This Directory cross-references the standardized section names required by 3 CCR 702-4, Regulation 4-2-34 (Concerning Section Names and the Placement of those Sections in Policy Forms by Health Carriers) with those used in this Certificate of Coverage.

1: Schedule of Benefits (Who Pays What) *See* ***Schedule of Benefits*** in the Attachments .....

2: Title Page (Cover Page) See ***Face Page of this document*** .....

3: Contact Us See ***Important Company Contact Information*** .....

4: Table of Contents See ***Table of Contents*** .....

5: Eligibility See ***Who is Covered*** .....

6: How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans) See ***Preferred Provider Information*** .....

7: Benefits/Coverage (What is Covered) See ***Medical Expense Benefits*** and ***Mandated Benefits*** .....

8: Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions) See ***Exclusions and Limitations***.. There is no corresponding section name for Pre-Existing Conditions. .....

9: Member Payment Responsibility See ***Schedule of Benefits*** and ***Coordination of Benefits Provision*** .....

10: Claims Procedure (How to File a Claim) See ***How to File a Claim for Injury and Sickness Benefits*** .....

11: General Policy Provisions See ***General Provisions*** .....

12: Terminations/Nonrenewal /Continuation See ***Effective and Termination Dates*** .....

13: Appeals and Complaints See ***Notice of Appeal Rights*** .....

14: Information on Policy and Rate Changes See ***Introduction*** and ***Effective and Termination Dates*** .....

15: Definitions See ***Definitions*** and ***Introduction*** .....

Table of Contents

Introduction 1
Section 1: Who Is Covered 1
Section 2: Effective and Termination Dates 1
Section 3: Extension of Benefits after Termination 2
Section 4: Pre-Admission Notification 2
Section 5: Preferred Provider and Out-of-Network Provider Information 2
Section 6: Medical Expense Benefits 4
Section 7: Mandated Benefits 12
Section 8: Coordination of Benefits Provision 18
Section 9: Definitions 21
Section 10: Exclusions and Limitations 27
Section 11: How to File a Claim for Injury and Sickness Benefits 29
Section 12: General Provisions 29
Section 13: Notice of Appeal Rights 30
Section 14: Online Access to Account Information 37
Section 15: ID Cards 37
Section 16: UHCSR Mobile App 37
Section 17: Important Company Contact Information 37
Section 18: Pediatric Dental Services Benefits 37
Section 19: Pediatric Vision Services Benefits 60
Section 20: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits 64

Additional Policy Documents
Schedule of Benefits ..... Attachment

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

No Insured Person will be denied coverage for medical/surgical or behavioral, mental or substance use disorder care as a result of self-harm or suicide attempt or completion.

Section 1: Who Is Covered

The Master Policy covers students 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 domestic degree-seeking students enrolled in at least one credit hour must purchase the plan, unless proof of comparable coverage is furnished. Online only degree students are not eligible. All international student (F and J visas), regardless of degree seeking status, are automatically enrolled in this insurance plan unless proof of comparable coverage is furnished.

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

Medicare Eligibility

Any person who has Medicare at the time of enrollment in this student insurance plan is not eligible for coverage under the Master Policy.

If an Insured Person obtains Medicare after the Insured Person is covered under the Master Policy, the Insured Person's coverage will not end due to obtaining Medicare.

As used here, "has Medicare" means that an individual is entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2025. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., July 31, 2026. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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

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

Section 3: Extension of Benefits after Termination

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

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

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

Section 4: Pre-Admission Notification

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

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

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

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

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

Section 5: Preferred Provider 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.

Balance and/or Surprise Billing

Colorado state law protects persons from “surprise billing”. This is sometimes called “balance billing” and it may happen when an Insured Person receives Covered Medical Expenses, other than ambulance services, from an Out-of-Network Provider in Colorado.

When an Insured Person cannot be balance billed:

Emergency Services
When an Insured Person receives Emergency Services for a Medical Emergency, benefits will be paid at the Preferred Provider cost-sharing amounts, which are Copayments, Coinsurance and Deductibles. The Insured Person cannot be balance billed for any other amounts.

Non-Emergency Services at a Preferred Provider or Out-of-Network Facility
The Hospital or facility must inform the Insured if they are at an Out-of-Network facility or at a Preferred Provider Facility. It must tell the Insured Person what types of services may be provided by an Out-of-Network Provider.

The Insured Person has the right to request that Preferred Providers perform all covered services. However, the Insured may have to receive medical services from an Out-of-Network Provider if a Preferred Provider is not available. When this happens, the most the Insured can be billed for Covered Medical Expenses is the Preferred Provider cost-sharing amount (Copayments, Coinsurance and Deductibles). These providers cannot balance bill the Insured.

Additional Protections:

- The Company will pay the Out-of-Network providers and facilities directly. The Insured Person is only responsible for paying the Preferred Provider cost-sharing for Covered Medical Expenses.
- The Company will count any amount the Insured pays for Emergency Services or the Out-of-Network services described above towards the Insured Person’s Preferred Provider Deductible and Out-of-Pocket Maximum.
- The Insured’s provider, Hospital or facility must refund any amount the Insured overpays within 60 days of the Insured reporting the payment to the provider.
- A provider, Hospital or other type of facility cannot ask the Insured to limit or give up these rights.

If an Insured Person receives services from an Out-of-Network Provider, Hospital or facility in any other situation, the Insured Person may still be balance billed, or the Insured may be responsible for the entire bill. If the Insured intentionally receives non-Emergency Services from an Out-of-Network Provider or facility, the Insured may also be balance billed.

Ambulance Information:
An Insured Person may be balance billed for Emergency Services received if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between Hospitals, are not subject to the state law against balance billing.

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:

Inpatient

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

2. **Intensive Care.**
   See 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.

   Benefits include opiate antagonists provided by the Hospital to the Insured Person upon discharge.

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

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

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

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

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

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

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

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

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

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

If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:

- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

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

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

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

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

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

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

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):

- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. 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, Congenital Condition, 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.
- Intravenous infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis, hemodialysis, and peritoneal dialysis.

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.

Benefits for prescription eye drops will be provided without regard to a coverage restriction for early refill of prescription renewals as long as:
- The refill is requested at least 21 days for a 30 day supply, 42 days for a 60 day supply or 63 days for a 90 day supply from the last delivered date to the insured; and
- The original prescriptions states that additional quantities are needed and the renewal does not exceed the number of additional quantities needed.

An additional bottle is available at the time the original prescription is filled, if the prescribing Physician indicates on the original prescription that an additional bottle is needed by the Insured for use in a day care center or adult day care program. The additional bottle is available once per 3 months if it does not exceed the prescription refills.

Medication-assisted treatment (MAT), a combination of behavioral therapies and medications approved by the federal food and drug administration, is available to treat substance use disorders.

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. Repair is covered unless necessitated by misuse.
- Orthotic devices that straighten or change the shape of a body part.

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

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

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

- Injury to Sound, Natural Teeth.
- Removal of impacted wisdom teeth.

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

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

29. **Mental Illness Treatment.**
Benefits will be paid for services received:

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

See also Benefits for Gender Affirming Care for Gender Dysphoria.

30. **Substance Use Disorder Treatment.**
Benefits will be paid for services received:

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

31. **Maternity.**
Same as any other Sickness for maternity-related services, including prenatal and postnatal care.

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

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

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

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

33. **Preventive Care Services.**
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Women's preventive health services include all FDA approved contraceptive methods, sterilization procedures, and patient education and counseling.

See also Benefits for Preventive Health Care.

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

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

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

Benefits will be paid for Medically Necessary:
- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Medical eye exams (dilated retinal exams).
- Preventive foot care for diabetes.
- Prescription Drugs, equipment, and supplies based on the Insured's specific medical needs, including:
  - Insulin pumps and supplies.
  - Blood glucose meters including continuous glucose monitors.
  - Insulin syringes with needles.
  - Blood glucose and urine test strips.
  - Ketone test strips and tablets.
  - Lancets and lancet devices.

See also Benefits for Diabetes.

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

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

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

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

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

39. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.

- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

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

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

"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.
- The clinical trial must have a written protocol that describes a scientifically sound study. It must have been approved by all relevant institutional review boards (IRBs) before the Insured is enrolled in the trial. The Company may, at any time, request documentation about the trial.

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

43. **Transplantation Services.**
Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.
Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

Health services related to living organ donation for an Insured Person who is a living organ donor are payable without imposition of any Deductibles, Copayments, Coinsurance, benefit maximums, waiting periods or other limitations for the living organ donation.

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

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

See also Benefits for Living Organ Donation.

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

45. **Acupuncture.**
See Schedule of Benefits.

46. **Infertility.**
Benefits are limited to the diagnosis and treatment, including laboratory procedures and X-rays, of involuntary infertility. This benefit also includes artificial insemination. This does not include benefits for donor semen, donor eggs and services related to their procurement and storage.

Additionally, all other services and supplies related to conception by artificial means, including but not limited to the following, are not covered:
- Prescription Drugs.
- In vitro fertilization.
- Ovum transplants.
- Gamete intra fallopian transfer
- Zygote intra fallopian transfer.

See also Benefits for Infertility and Standard Fertility Preservation Services.

47. **TMJ Disorder.**
Same as any other Sickness and limited to the following services only:
- Diagnostic X-Ray services.
- Laboratory procedures.
- Physical therapy.
- Surgery.

48. **Morbid Obesity Treatment.**
Benefits are provided for Covered Medical Expenses incurred for the Medically Necessary treatment of Morbid Obesity limited to the following:

- Surgery for Morbid Obesity.

- Treatment for Morbid Obesity associated with serious and life threatening disorders such as diabetes mellitus and hypertension. Benefits will be provided only upon written request for treatment with a treatment plan written by a Physician, and services or treatment must meet the Company's medical criteria.

For the purpose of this benefit, morbid obesity means a body weight of two times the normal body weight or greater or 100 pounds in excess of normal body weight. Normal body weight is determined using generally accepted height and weight tables for a person of the same age, sex, height and frame.

Section 7: Mandated Benefits

BENEFITS FOR CERVICAL CANCER VACCINES

Benefits are payable for the cost of cervical cancer vaccinations for all female Insured Persons for whom a vaccination is recommended by the Advisory Committee on Immunization practices of the United States Department of Health and Human Services.

BENEFITS FOR CLEFT LIP OR CLEFT PALATE

Benefits will be paid the same as any other Sickness for treatment of newborn children born with cleft lip or cleft palate or both. Benefits shall include the Medically Necessary care and treatment including oral and facial surgery; surgical management; the Medically Necessary care by a plastic or oral surgeon; prosthetic treatment such as obturators, speech appliances, feeding appliances; Medically Necessary orthodontic and prosthodontic treatment; habilitative speech therapy, otolaryngology treatment; and audiological assessments and treatment.

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

BENEFITS FOR DIABETES

Benefits will be paid for Covered Medical Expenses for all medically appropriate and necessary equipment, supplies, and outpatient diabetes self-management training and educational services including nutritional therapy if prescribed by a Physician.

Diabetes outpatient self-management training and education shall be provided by a Physician with expertise in diabetes.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy; however the Insured will not be required to pay more than $100 for a covered Prescription Drug of insulin per 30-day supply regardless of the amount or type of insulin needed to fill the Insured Persons Prescription.

BENEFITS FOR HEARING AIDS FOR MINOR CHILDREN

Benefits will be paid for Covered Medical Expenses for Hearing Aids for a Minor Child who has a hearing loss that has been verified by a licensed Physician and a licensed Audiologist. The Hearing Aid shall be medically appropriate to meet the needs of the Minor Child according to accepted professional standards.

Benefits shall include the purchase of the following:

1. Initial Hearing Aids and replacement Hearing Aids not more frequently than every five years;
2. A new Hearing Aid when alterations to the existing Hearing Aid cannot adequately meet the needs of the Minor Child; and
3. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to professional standards.

“Hearing Aid” means amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. “Hearing Aid” shall include any parts or ear molds.

“Minor Child” means an Insured Person under the age of eighteen.

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

BENEFITS FOR MEDICAL FOODS

Benefits are payable for Medical Foods needed to treat inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as specified below.

If the policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Sickness for Medical Foods, to the extent Medically Necessary, for home use for which a Physician has issued a written, oral or electronic prescription. Benefits will not be provided for alternative medicine.
Coverage includes but is not limited to the following diagnosed conditions: phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; and propionic acidemia. Benefits do not apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

There is no age limit on the benefits provided for inherited enzymatic disorders except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

Medical foods means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy that are specifically designed and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients and are to be consumed or administered enterally either via tube or oral route under the direction of a Physician.

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

BENEFITS FOR ORAL ANTICANCER MEDICATION

Benefits will be provided for prescribed, orally administered anticancer medication that has been approved by the Federal Food and Drug Administration and is used to kill or slow the growth of cancerous cells.

The orally administered medication shall be provided at a cost to the Insured not to exceed the Coinsurance percentage or the Copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose.

The medication provided pursuant to this benefit shall:

1. Only be prescribed upon a finding that it is Medically Necessary by the treating Physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice;
2. Be clinically appropriate in terms of type, frequency, extent site, and duration; and
3. Not be primarily for the convenience of the Insured or Physician.

This benefit does not require the use of orally administered medications as a replacement for other cancer medications, nor does it prohibit the Company from applying an appropriate formulary or other clinical management to any medication described in this benefit.

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

BENEFITS FOR PREVENTIVE HEALTH CARE

Benefits will be provided at no cost for the following Preventive Health Care services, in accordance with the A or B Recommendations of the Task Force for the particular Preventive Health Care service:

1. Unhealthy alcohol use screening for adolescents and adults, and perinatal maternal counseling for persons at risk, to be provided by their Physician.
2. Cervical Cancer Screening.
3. An annual Preventive Breast Cancer Screening Study using the appropriate noninvasive imaging modality or combination of modalities recognized by the American College of Radiology, the National Comprehensive Cancer Network, or their successor entities, for all Insured Persons having at least one risk factor for breast cancer, including:
    a. A family history of breast cancer.
    b. Being forty years of age or older.

c. An increased lifetime risk of breast cancer determined by a risk factor model such as Tyrer-Cuzick, BRCAPRO, or GAIL or by other clinically appropriate risk assessment models.

"Breast Cancer Screening Study" means:

a. A mammogram, with or without a clinical exam, for Insureds at average risk.
b. A mammogram, using noninvasive imaging modality or modalities, as recommended by a Physician.
c. A mammogram, with or without a clinical exam, and medically recommended subsequent noninvasive imaging modality or modalities that fall within appropriate use guidelines noted above, for the early detection of breast cancer for Insureds at average risk who have an incomplete mammogram result or for Insureds at high risk.

4. Cholesterol screening for lipid disorders.
5. Colorectal cancer screening coverage for tests for the early detection of colorectal cancer and adenomatous polyps. Benefits shall also be provided to an Insured Person who is at a high risk for colorectal cancer, including an Insured Person who has a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by a Physician.
6. Child health supervision services and childhood immunizations pursuant to the schedule established by the ACIP.
7. Influenza vaccinations pursuant to the schedule established by the ACIP.
8. Pneumococcal vaccinations pursuant to the schedule established by the ACIP.
9. PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use as well as baseline and monitoring services in accordance with Article 16 of Title 10 of the Colorado Revised Statutes, and the Affordable Care Act (ACA).
10. Tobacco use screening of adults and tobacco cessation interventions by the Insured Person's Physician.
11. An annual Mental Health Wellness Examination of up to sixty minutes that is performed by a qualified mental health care provider.

    "Mental Health Wellness Examination" means an examination that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include:

    a. Observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports, and discussion of potential options for medication.
    b. Age-appropriate screenings or observations to understand an Insured Person's mental health history, personal history, and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews, and questions.

    "Qualified Mental Health Care Provider" means:

    a. A Physician licensed to practice medicine who has specific board certification or training in psychiatry or other mental or behavioral health care areas.
    b. A Physician Assistant who has training in psychiatry or mental health.
    c. A Psychologist.
    d. A Clinical Social Worker.
    e. A Marriage and Family Therapist.
    f. A professional Counselor.
    g. An Addiction Counselor.
    h. An Advanced Practice Registered Nurse with specific training in Psychiatric Nursing.
12. Any other preventive services included in the A or B Recommendation of the Task Force or required by federal law.
13. Counseling, prevention, screening, and treatment of a sexually transmitted infection for all Insured's regardless of gender. Benefits shall also include coverage for HIV prevention drugs and services necessary for initiation and continued use of HIV prevention drugs, including office visits, testing, vaccinations, and monitoring services.
14. Sterilization services, regardless of the Insured's sex or gender.
15. The total cost of abortion care.

"ACIP" means the advisory committee on immunization practices to the centers for disease control and prevention in the federal Department of Health and Human Services, or any successor entity.

"A Recommendation" means a recommendation adopted by the task force that strongly recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit of the preventive health care service is substantial.

"B Recommendation" means a recommendation adopted by the task force that recommends that clinicians provide a preventive health care service because the task force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

"Task force" means the U.S. preventive services task force, or any successor organization, sponsored by the agency for healthcare research and quality, the health services research arm of the federal Department of Health and Human Services.

The Policy Deductible, Copays and Coinsurance will not be applied to this benefit.

Benefits shall be subject to all other limitations or any other provisions of the Policy.

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid for actual charges incurred for an annual screening by a Physician for the early detection of prostate cancer. Benefits will be payable for one screening per year for any male Insured 50 years of age or older. One screening per year shall be covered for any male Insured 40 to 50 years of age who is at risk of developing prostate cancer as determined by the Insured's Physician. The screening shall consist of the following tests:

1. A prostate-specific antigen (PSA) blood test; and
2. Digital rectal examination.

The policy Deductible will not be applied to this benefit and this benefit will not reduce any diagnostic benefits otherwise allowable under the Policy.

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

BENEFITS FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Mental Illness for Covered Medical Expenses related to the assessment, diagnosis and treatment, including Applied Behavior Analysis, of Autism Spectrum Disorders. Treatment for Autism Spectrum Disorders must be prescribed or ordered by a licensed Physician or licensed psychologist.

"Applied behavior analysis" means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

"Autism Spectrum Disorders" include the following neurobiological disorders: autistic disorder, asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time of diagnosis.

"Treatment for Autism Spectrum Disorders" shall be for treatments that are Medically Necessary and shall include:

1. Evaluation and assessment services;
2. Behavior training and behavior management and applied behavior analysis, including but not limited to, consultations, direct care, supervision, or treatment, or any combination thereof, provided by autism services providers;
3. Habilitative or rehabilitative care, including but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies;
4. Psychiatric care;
5. Psychological care, including family counseling;
6. Therapeutic care; and
7. Pharmacy care and medication if provided for in the policy.

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

BENEFITS FOR CONTRACEPTIVES

Benefits will be provided for the single dispensing or furnishing of Contraception intended to last the Insured Person for a duration of twelve months, as permitted by the Insured Person's prescription, dispensed or furnished at one time, unless requested otherwise by the Insured Person.

"Contraception" means a medically acceptable drug, device, or procedure used to prevent pregnancy.

"Dispensing entity" means a pharmacy, other outlet, or other facility registered by the state board of pharmacy.

The Company shall:

1. Allow for the continuous use of clinically appropriate Contraception as determined by a Physician.
2. Reimburse a Physician or a Dispensing Entity that is a Preferred Provider for dispensing or furnishing Contraception.
3. Include an alternative prescribed contraception without prior authorization, step therapy, or cost sharing if, in the determination and judgment of the Physician, the alternative prescribed contraception is Medically Necessary.

4. Make available an easily accessible, timely, and transparent exceptions process for an Insured Person to obtain coverage, without cost sharing, for Medically Necessary contraception that is not otherwise included in the formulary or available without cost sharing.

The Company shall not Implement step therapy, prior authorization, or utilization management practices, including quantity or fill limits, for Contraception if the practice would result in an Insured Person receiving less than a twelve-months' duration of Contraception dispensed or furnished either at one time, or if requested by the Insured Person at the point of dispensing or furnishing, over a twelve-month period.

Benefits also include point-of-sale coverage for over-the-counter Contraception at Preferred Provider dispensing entities without prior authorization, step therapy, utilization management, or cost sharing. A prescription for coverage of FDA-approved, cleared, or granted over-the-counter Contraception is not required. The Insured Person will need to pay for the over-the-counter Contraception at the point of service and may then submit a request for reimbursement along with the paid receipts.

Contraception provided by a Preferred Provider shall not be subject to any Deductible, Copayment, or Coinsurance but shall be subject to all other limitations and provisions of the Policy. Contraception provided by an Out-of-Network Provider shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR LIVING ORGAN DONATION

Benefits will be provided for Health Care Services related to living organ donation for an Insured Person who is a living organ donor.

"Health care services" means a procedure to harvest an organ of a living organ donor and all services required before and after the procedure.

"Living organ donor" means a living Insured Person who has donated all or part of an organ.

Benefits for living organ donation shall not be subject to any Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR INFERTILITY AND STANDARD FERTILITY PRESERVATION SERVICES

Benefits will be provided for the diagnosis of and treatment for Infertility and Standard Fertility Preservation Services.

Benefits will be paid for three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the ASRM, using single embryo transfer when recommended and medically appropriate.

"Diagnosis of and treatment for infertility" means the procedures and medications recommended by a licensed Physician that are consistent with established, published, or approved medical practices or professional guidelines from ACOG or ASRM for diagnosing and treating infertility.

"Standard fertility preservation services" means procedures and services that are consistent with established medical practices or professional guidelines published by ASRM or ASCO for an Insured Person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.

"ASRM" means the American society for reproductive medicine or its successor organization.
"ACOG" means the American college of obstetricians and gynecologists or its successor organization.

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

BENEFITS FOR NONPHARMACOLOGICAL ALTERNATIVE TREATMENT TO OPIOIDS

Benefits will be paid the same as any other Sickness for nonpharmacological treatment for an Insured with a pain diagnosis where an opioid might be prescribed.

Benefits shall include services for a minimum of:

1. Six physical therapy visits.
2. Six occupational therapy visits.
3. Six chiropractic visits.

4. Six acupuncture visits.

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

BENEFITS FOR GENDER AFFIRMING CARE FOR GENDER DYSPHORIA

Benefits will be paid the same as any other Sickness for Medically Necessary gender affirming care for gender dysphoria.

Benefits shall include services for:

1. Hormone therapy.
2. Genital and non-genital surgical procedures.
3. Blepharoplasty (eye and lid modification).
4. Face/forehead and/or neck tightening.
5. Facial bone remodeling for facial feminization.
6. Genioplasty (chin width reduction).
7. Rhytidectomy (cheek, chin, and neck).
8. Cheek, chin, nose implants.
9. Lip lift/augmentation.
10. Mandibular angle augmentation/creation/reduction (jaw).
11. Orbital recontouring.
12. Rhinoplasty (nose reshaping).
13. Laser or electrolysis hair removal.
14. Breast/chest augmentation, reduction, construction.

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

BENEFITS FOR DOULA SERVICES

Benefits will be paid the same as any other Sickness for Doula Services.

“Doula” means a trained birth companion who provides personal, nonmedical support to pregnant and postpartum Insureds and their families prior to childbirth, during labor and delivery, and during the postpartum period and who has the qualifications and training required by the state.

“Doula Services” means services provided by a Doula.

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

BENEFITS FOR PANDAS AND PANS

Benefits will be paid the same as any other Sickness for prophylaxis, diagnosis, and treatment of PANDAS and PANS.

“PANDAS” means pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections.

“PANS” means pediatric acute-onset neuropsychiatric syndrome.

Benefits shall include treatments and therapies prescribed or ordered by a Physician, including:

1. Antibiotics.
2. Medication and psychological and behavioral therapies to manage neuropsychiatric symptom.
3. Immunomodulating medicines.
4. Plasma exchange.
5. Intravenous immunoglobulin therapy.

Benefits shall include up to six immunomodulatory courses of intravenous immunoglobulin therapy when the following conditions have been met:

1. Clinically appropriate trials, which may be done concurrently, of two or more less intensive treatments:
    a. Were not effective.
    b. Were not tolerated.

c. Did not result in sustained improvement in symptoms, as measured by a lack of clinically meaningful improvement on a validated instrument directed at the Insured's primary symptom complex.

2. The Insured's treating Physician recommends the treatment or therapy, or the treatment or therapy is recommended by a pediatric or, for an adolescent Insured, and adult subspecialist, after consultation with the treating Physician.

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

Section 8: Coordination of Benefits Provision

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

Definitions

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

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

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

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

   Plan does not include any of the following:

   - Hospital indemnity coverage benefits or other fixed indemnity coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage

and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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

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

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

Section 9: Definitions

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 a state *All Payer Model Agreement*.
   - 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 a state *All Payer Model Agreement*.
   - 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 a state *All Payer Model Agreement*.
   - 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; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

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

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

COVERED MEDICAL EXPENSES means health care services and supplies which are all of the following:

1. Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness or Injury.
2. Medically Necessary.
3. Specified as a covered medical expense in this Certificate under the Medical Expense Benefits or in the Schedule of Benefits.
4. Not in excess of the Allowed Amount or the Recognized Amount when applicable.
5. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
6. Not excluded in this Certificate under the Exclusions and Limitations.
7. In excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

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

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

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

EMERGENCY SERVICES means, with respect to a Medical Emergency, both:

1. An appropriate medical screening examination 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 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)*).

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.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Company has the right to seek expert opinion in determining whether services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use such expert opinion shall be determined by the Company.

The Company develops and maintains clinical policies that describe the generally accepted standards of medical practice scientific evidence, prevailing medical standards, and clinical guidelines supporting the Company's determinations regarding specific services. These clinical policies are available through UHCprovider.com.

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

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

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

HOSPITAL means a health institution planned, organized, operated, and maintained to offer facilities, beds, and services over a continuous period exceeding twenty four (24) hours to individuals requiring diagnosis and treatment for illness, Injury, deformity, abnormality, or pregnancy. Clinical laboratory, diagnostic X-ray, and definitive medical treatment under an organized medical staff shall be provided within the institution. Treatment facilities for emergency and surgical services shall be provided either within the institution or by contractual agreement for those services with another licensed Hospital. Services provided by contractual agreement shall be documented by a well-defined plan for the provision of contracted services, related to community needs. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medicine and rehabilitation, X-ray therapy, and similar specialized treatment.

For the purpose of Mental Illness or Substance Use Disorder treatment, the surgery requirement does not apply.

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

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

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

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

INSURED PERSON means: the Named Insured. 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 the absence of immediate medical attention 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.

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 Generally Accepted Standards of Medical Practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most clinically appropriate supply, frequency, duration, or level of service which can safely be provided to the Insured.

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

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

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

MEDICARE means Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder, regardless of etiology, listed in the mental health or psychiatric diagnostic categories in the current: 1) Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; 2) International Statistical classification of diseases and related health problems; and 3) Diagnostic classification of mental health and developmental disorders of infancy and early childhood. The fact that a disorder is listed in one of these manuals does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

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

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 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 means any of the following:

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.
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. An *All Payer Model Agreement* if adopted.
2. State law.
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

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

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

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

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder, regardless of etiology, in the current American Society of Addiction Medicine (ASAM) criteria. The fact that a disorder is listed in one of these manuals does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.

TELEHEALTH/TELEMEDICINE means a mode of delivery of health care services through telecommunication systems, including information, electronic , and communication technologies to facilitate the assessment, diagnosis, consultation, treatment, education, care management or self-management of an Insured Person's health when the Insured and the Provider are not at the same site. Consultations by telephone or facsimile are not covered unless provided through HIPAA compliant interactive audio-visual communication or the use of a HIPAA compliant application via cellular telephone.

URGENT CARE CENTER means an entity 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.

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. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Learning disabilities. Milieu therapy. Parent-child problems.
   This exclusion does not apply to benefits specifically provided in the Policy.
2. Biofeedback, except as specifically provided in the Policy.
3. Cosmetic procedures, except as specifically provided in the Policy or reconstructive procedures to:
   - Correct an Injury or treat a Sickness.
   - Treat a congenital hemangioma on the face or neck for an Insured age 18 or younger.
   - Correct a congenital defect, disease or anomaly for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
5. Dental treatment except:
   - For accidental Injury to Sound, Natural Teeth.
   - As specifically provided in the Schedule of Benefits.

- As described under Dental Treatment in the Policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.

6. Elective Surgery or Elective Treatment.
7. Foot care for the following, except as specifically provided in the Policy:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
8. Health spa or similar facilities. Strengthening programs.
9. Hearing examinations. Hearing aids.
10. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of a Congenital Condition, infection, or Injury.
    - Hearing Aids specifically provided for in Benefits for Hearing Aids for Minor Children.
    - Hearing exams and tests to determine the need for hearing correction.
11. Hypnosis.
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. Injury sustained while:
    - Participating in any contest or competition of intercollegiate.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
14. Investigational services.
15. Nuclear, chemical or biological contamination, whether direct or indirect. “Contamination” means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death.
16. Commission of or attempt to commit a felony. Fighting.
17. Prescription Drugs, services or supplies as follows, except as specifically provided in the Policy:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
    - Immunization agents, except as specifically provided in the Policy.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Fertility agents or sexual enhancement drugs.
    - Growth hormones.pg.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
18. Reproductive services for the following, except as specifically provided in the Policy:
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
    - Premarital examinations.
    - Impotence, organic or otherwise.
19. 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.
20. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses.

    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.

21. Preventive care services which are not specifically provided in the Policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.
22. Speech therapy, except as specifically provided in the Policy. Naturopathic services.
23. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
24. Supplies, except as specifically provided in the Policy.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
28. Weight management. Weight reduction programs. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Treatment for Morbid Obesity associated with serious and life threatening disorders such as diabetes mellitus and hypertension is covered. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

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

In the event of Injury or Sickness, students should:

1. Report to the Student Health Center or Infirmary for treatment, 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 under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

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 14 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 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid 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.

Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

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

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

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

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

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

Section 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 calendar days after receipt of a notice of an Adverse Determination, an Insured Person or Designated Representative may submit a written request for an Internal Review of an Adverse Determination.

In order to secure an Internal Review after the receipt of the notification of a benefit denied due to a contractual exclusion, the Insured Person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the policy exclusion does not apply to the denied benefit. The Internal Appeal will be evaluated by a Physician who shall consult with an appropriate clinical peer or peers unless the reviewing Physician is a clinical peer. The Physician and clinical peer(s) shall not have been involved in the initial Adverse Determination.

In conducting the review, the reviewers shall take into consideration all comments, documents, records and other information regarding the request submitted by the Insured Person without regard to whether the information was submitted or considered in making the initial Adverse Determination. If the appeal is due to applicability of a contractual exclusion, the determination shall be made on the basis of whether the contractual exclusion applies to the denied benefit.

An Insured Person does have the right to attend or to have a representative in attendance at the Internal Review and is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits for the reviewers to consider when conducting the 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 Designated Representative shall have 45 calendar days to respond to any new or additional evidence or rationale.

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

1. For a Prospective Review, the notice shall be made no later than 15 calendar days after the Company's receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 30 calendar days after the Company's receipt of the grievance.
3. If the Final Adverse Decision is provided orally, a written or electronic shall be provided within 3 calendar days following the oral notification.

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 name, title and qualifying credentials of the physician evaluating the appeal and the qualifying credentials of the clinical peer(s) which whom the physician consults;
2. A statement of the reviewers' understanding of the Insured Person's request for a review of Adverse Determination;
3. The reviewers' decision in clear terms; and a reference to the evidence or documentation used as the basis for the decision;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
    a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
    b. Reference to the specific Policy provisions upon which the determination is based;
    c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
    d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
    e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;

f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;

5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

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

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

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

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

Expedited Internal Review Process

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

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

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

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

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

RIGHT TO EXTERNAL INDEPENDENT REVIEW

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

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Designated Representative has four months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Company and shall include a completed External Review Request form as required by the Colorado Division of Insurance, and a signed consent authorizing the Company to disclose Protected Health Information pertinent to the External Review. The date of receipt shall be calculated to be no less than three calendar days after the date the notice is postmarked by the Company. If the deadline for filing a request ends on a weekend or holiday, the deadline shall be extended to the next business day. Upon request of an External Review, the Company shall provide the Insured Person or the Designated Representative with the appropriate forms to request the review.

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

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

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

The Insured Person has the right to a Standard External Review upon written notice of the Company's final Adverse Determination. No expedited External Reviews are allowed for retrospective Adverse Determinations.

All notification requirements within the Standard External Review process shall be provided electronically, by facsimile or by telephone and followed by a written confirmation.

1. Within two business days after receiving the SER request notice, the Company will deliver a copy of the request notice to the Commissioner.
2. The Company will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
3. Within five business days after receipt of the SER request, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Designated Representative in writing whether the request is complete and eligible for a SER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Designated Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. After receiving notice that a request is eligible for SER, the Commissioner shall, within two business days:
   a. Assign an Independent Review Organization (IRO) from the Commissioner's approved list;
   b. Notify the Company of the name and address of the assigned IRO to which the appeal should be sent;
   c. After notification from the Commissioner, the Company shall notify the Insured Person and, if applicable, the Designated Representative, electronically, by facsimile, or by telephone, followed by written confirmation that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Designated Representative may, within two business days following receipt of the notice,

provide the Commissioner with documentation regarding a potential conflict of interest with the IRO; and (iii) if no conflict of interest is present, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

d. If the Insured Person or Designated Representative provides documentation of a conflict of interest and the Commissioner determines the assigned IRO does in fact present a conflict of interest, the Commissioner shall assign, within one business day, a different IRO to conduct the external review. Upon the reassignment of the IRO, the Commissioner shall notify the Company electronically or by facsimile of the name and address of the new IRO. The Commissioner will also notify the Insured Person and, if applicable, the Designated Representative in writing of the Commissioner's determination of the potential conflict of interest, and the name and address of the new assigned IRO.

5. a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination, including an index of all submitted documents. The Company's failure to provide the documents and information will not delay the SER.
   b. The IRO, within two business days of receipt documentation from the Company, shall deliver to the Insured Person the index of all materials that the Company has submitted to the IRO. The Company, upon request from the Insured Person, shall provide all relevant information supplied to the IRO that is not confidential or privileged under state or federal law concerning the external review.
   c. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, immediately advise the Commissioner, the Company, the Insured Person, and the Designated Representative, if any, of its decision.
6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Designated Representative.
7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
   b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
   c. If the Company reverses its decision, the Company shall provide written notification within one business day to the Commissioner, the Insured Person, the Designated Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
8. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person, the Physician or other health care professional of the Insured Person, and, if applicable, the Designated Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

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

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

The Insured Person or Insured Person's Designated Representative's request for an Expedited External Review must include a Physician's certification that the Insured Person's medical condition meets the above criteria.

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

2. Upon receipt of a request for an EER and the Physician's certification, the Company shall immediately review the request to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
3. When the Company receives an incomplete EER request, the Company shall notify the Insured Person and the Designated Representative, if applicable, that the request fails to meet the filing procedures no later than 24 hours after the incomplete request was received.
4. Upon receipt and review of the request for an EER, the Company shall notify and send a copy of the request electronically, by telephone, by facsimile, or any other available expeditious method to the Commissioner within one business day.
5. When a request is complete and eligible for an EER, the Commissioner shall within one business day assign an Independent Review Organization (IRO) from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
   a. Within one business day of receiving notice of the assigned IRO from the Commission, the Company shall notify the Insured Person and, if applicable, the Designated Representative, electronically, by facsimile, or by telephone followed by written confirmation and a description of the IRO assigned to conduct the review.
   b. The Company shall immediately provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
   c. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6. a. If the EER is related to an Adverse Determination for which the Insured Person or the Designated Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
   b. The IRO shall immediately notify the Insured Person and the Designated Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
   a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination, in whole or in part; and
   b. Notify the Commissioner, the Company, the Physician or other health care professional of the Insured Person, and, the Insured Person.
8. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

An External Review decision is binding on the Company except to the extent the Company has other remedies available under federal or state law. An External Review decision is binding on the Insured Person except to the extent the Insured Person has other remedies available under applicable federal or state law. An Insured Person or Designated 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.

The Company shall be responsible for the costs associated with the independent external review.

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 prospective or retrospective benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, efficiency, 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.

Designated Representative means:
1. A person, including the treating Physician 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, including but not limited to a guardian, agent under a power of attorney, a proxy, or a designee of the Colorado Department of Health Care Policy and Financing;
3. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
4. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

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

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

Prospective Review means Utilization Review performed: 1) prior to an admission or the provision of a health care service or course of treatment requested by an Insured Person, Designated Representative, medical facility or Physician; 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 Utilization Review conducted after services have been provided to a patient but does not include the review of a claim that is limited to an evaluation of reimbursement levels, the veracity of documentation, accuracy of coding or adjudication for payment.

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. For the purposes of this regulation, Utilization Review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of an Insured Person's medical circumstances when necessary to determine if an exclusion applies in a given situation.

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

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

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
303-894-7499; outside metro Denver: 1-800-930-3745
dora_Ins_website@state.co.us

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.
- 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 the primary Insured; 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
11399 16th Court North, Suite 110
St. Petersburg, FL 33716
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 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, the Company has a right to deny the claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

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

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

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

Network Benefits:

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

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

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

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

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

When benefit limits apply, the limit stated refers to any combination of Network Benefits and 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 - (Subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) Limited to two times per 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**
Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient D0160 - Detailed and extensive oral evaluation - problem focused, by report		
Intraoral Radiographs (X-ray) Limited to one series of films per 36 months. D0210 - Intraoral - comprehensive series of radiographic images D0709 - Intraoral - comprehensive series of radiographic images - image capture only D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	50%	50%
The following services are limited to two per 12 months. D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0374 - Intraoral tomosynthesis - periapical radiographic image D0389 - Intraoral tomosynthesis - periapical radiographic image - image capture only D0706 - Intraoral - occlusal radiographic image - image capture only	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**
D0707 - Intraoral - periapical radiographic image - image capture only		
Any combination of the following services is limited to two series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only D0708 - Intraoral - bitewing radiographic image - image capture only	50%	50%
Limited to one time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only D0702 - 2-D Cephalometric radiographic image - image capture only	50%	50%
The following service is limited to two images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%	50%
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 D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	50%	50%
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to two 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**
D1110 - Prophylaxis - adult D1120 - Prophylaxis - child		
Fluoride Treatments The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish	50%	50%
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	50%	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 D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant	50%	50%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings)	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 services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent 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 (anterior) D2989 - Excavation of a tooth resulting in the determination of non-restorability	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces 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 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	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**
D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following services are limited to one time per tooth every 60 months. D2950 - Core buildup, including any pins when required D2951 - Pin retention - per tooth, in addition to restoration	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration) D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)		
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) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - premolar 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) D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior 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	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 services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 36 months. 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 one 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 one every 36 months. 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 D4286 - Removal of non-resorbable barrier	50%	50%
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.	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**
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		
The following services are limited to one 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 limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%	50%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 60 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)	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**
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) 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.	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**
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		
The following services are limited to rebasing performed more than six months after the initial insertion with a frequency limitation of one 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)	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**
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%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic	50%	50%
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 one 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	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**
D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal		
The following services are not subject to a frequency limit. D6930 - Re-cement or re-bond FPD D6980 - FPD repair necessitated by restorative material failure	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root 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, impacted teeth only	50%	50%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit.	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**
D7280 - Surgical access exposure of an unerupted tooth		
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 spaces, per quadrant	50%	50%
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst D7510 - Incision and drainage of abscess, intraoral soft tissue 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	50%	50%
The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the	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**
exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative treatment of dental pain per visit		
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration	50%	50%
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
The following services are limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to one time every 60 months. 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 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	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**
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 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 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		

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**
D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6089 - Accessing and retorquing loose implant screw per screw 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 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 D6105 - Removal of implant body not requiring bone removal nor flap elevation 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		

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**
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 D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant		
The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant D6107 - Guided tissue regeneration - non-resorbable barrier, per implant	50%	50%
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. 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. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition	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**
D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular		

Section 3: Pediatric Dental Exclusions

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

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

15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this section to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from 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 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 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 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 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 Vision Care Providers are determined as a percentage of the provider's billed charge.

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

Policy Deductible

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

What Are the Benefit Descriptions?

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and 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.

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. 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.

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.		

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% 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.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 20: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When Are Benefits Available for Prescription Drug Products?

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

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.

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.

If the Insured does not use a Network Pharmacy, no benefits are available and the Insured will be responsible for paying the full cost for the Prescription Drug.

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 Charge for the Prescription Drug Product.
- 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, unless adjusted based on the drug manufacturer's packaging size. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

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

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 or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

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.

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, benefits will be paid based on the out-of-Network Benefit for that Prescription Drug Product.

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

The Company designates certain Network Pharmacies to be Preferred Specialty Network Pharmacies. The Company may periodically change the Preferred Specialty Network Pharmacy designation of a Network Pharmacy. These changes may occur without prior notice to the Insured unless required by law. The Insured may find out whether a Network Pharmacy is a Preferred Specialty Network Pharmacy at www.uhcsr.com 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, 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 (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), 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.

For Insured Persons with stage four advanced metastatic cancer, step therapy requirements do not apply to covered Prescription Drug Products that have been approved by the United States Food and Drug Administration if the use of the approved Prescription Drug Product is consistent with:

- The United States Food and Drug Administration-approved indication;
- The National Comprehensive Cancer Network Drugs and Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; or
- Peer-reviewed medical literature.

An Insured Person is not required to undergo step therapy or obtain prior authorization for HIV infection prevention drugs prescribed and dispensed by a pharmacist in accordance with state law. "HIV infection prevention drug" means preexposure prophylaxis, post-exposure prophylaxis, or other drugs approved by the United States Food and Drug Administration for the prevention of HIV infection. Benefits are provided for HIV preventive medications as described under the UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits. These medications are provided at zero cost share when the medication meets the definition of a PPACA Zero Cost Share Preventive Care Medication as defined under the UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits.

When a medication prescribed to treat a serious mental illness requires step therapy, an Insured Person is required to try no more than one (1) prescription drug product, other than the drug prescribed by the provider, prior to the approval of the drug prescribed by the Insured Person's provider. In addition, the Insured Person's provider may submit a completed Serious Mental Illness Step Therapy Exception form for use in exceptions to Step Therapy for an Insured Person with a serious mental illness if at least one of the following conditions are met:

- The provider attests that the required prescription drug is contraindicated or will likely cause an adverse reaction or harm to the Insured Person.
- The required prescription drug is ineffective based on the known clinical characteristics of the Insured Person and the know characteristics of the prescription drug regimen.
- The Insured Person has tried, while under the Insured Person's current or previous health benefit plan, the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and the use of the prescription drug by the Insured Person was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- The Insured Person, while on the Insured Person's current or previous health benefit plan, is stable on a prescription drug selected by the prescribing Physician for the medical condition under consideration after undergoing step therapy or after having sought and received a step-therapy exception.

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

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.

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

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will 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 Benefit. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
  - AHFS Drug Information (AHFS DI) under therapeutic uses section.
  - Elsevier Gold Standard's Clinical Pharmacology under the indications section.

    - DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb.
    - National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.
- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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

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

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

New Prescription Drug Product means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:
- The date it is placed on a tier by the Company's PDL Management Committee.
- December 31st of the following calendar year.

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

Out-of-Network Reimbursement Rate means the amount the Company will pay to reimburse an Insured for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA means Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications means the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible) as required by applicable law under any of the following:
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- Certain immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings 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 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 (with spacers).
- 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 have essentially the same efficacy and adverse effect profile.

Unproven Service(s) means services, including medications and devices, regardless of U.S. Food and Drug Administration (FDA) approval, that are determined not to be effective for the treatment of the medical or behavioral health condition or not determined to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature.

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-controlled studies, cross-sectional studies, and systematic reviews (with or without meta-analyses) of such studies.

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. The Insured can view these policies at liveandworkwell.com.

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

Usual and Customary Charge 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. Prescription Drug Products dispensed outside the United States, except as required for a Medical Emergency.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
5. 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.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
9. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
10. Certain unit dose packaging or repackagers of Prescription Drug Products.
11. Medications used for cosmetic or convenience purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
14. 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.)
15. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
16. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.
17. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to

six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

19. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
20. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
21. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
22. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
25. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
26. A Prescription Drug Product that contains marijuana, including medical marijuana.

Right to Request an Exclusion Exception

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

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

Expedited External Review

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

Schedule of Benefits

Colorado School of Mines
2025-4059-1
METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 91.950%
Injury and Sickness Benefits

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

Deductible Preferred Provider	$0
Deductible Out-of-Network Provider	$1,000 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	60% except as noted below
Out-of-Pocket Maximum Preferred Provider	$2,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$4,000 (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. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. “Network area” means the 50 mile radius around the local school campus the Named Insured is attending.

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 certain Preferred Provider facilities 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. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays.

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Routine/Preventative Labs referred by the SHC to LabCorp will be paid at 100%. All Other labs referred by the SHC to Lab Corp will be paid at 80%. Policy Exclusions and Limitations do not apply.

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 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 Expense	$250 Copay per Hospital Confinement Allowed Amount	Allowed Amount not subject to Deductible
Intensive Care	Allowed Amount	Allowed Amount not subject to Deductible
Hospital Miscellaneous Expenses	Allowed Amount	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.	Allowed Amount	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.	Allowed Amount	Allowed Amount After Deductible
Anesthetist Services	Allowed Amount	Allowed Amount After Deductible
Registered Nurse's Services	Allowed Amount	Allowed Amount After Deductible
Physician's Visits	Allowed Amount	Allowed Amount not subject to Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount	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.	Allowed Amount	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount	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.	Allowed Amount	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount	Allowed Amount after Deductible
Physician's Visits	$25 Copay per visit 100% of Allowed Amount	$25 Copay per visit Allowed Amount after Deductible
Physiotherapy	Allowed Amount	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Limits per Policy Year as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy Separate physical, occupational, and speech therapy limits apply to rehabilitative and Habilitative Services. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.		
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$100 Copay per visit Allowed Amount	$100 Copay per visit 80% of Allowed Amount not subject to Deductible
Diagnostic X-ray Services	Allowed Amount	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount	Allowed Amount after Deductible
Tests & Procedures	Allowed Amount	Allowed Amount after Deductible
Injections	Allowed Amount	Allowed Amount after Deductible
Chemotherapy	Allowed Amount	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information. For a twin-pack of epinephrine injectors, regardless of the type of epinephrine injector, the total amount of Copayments or Coinsurance shall not exceed $60.	*UnitedHealthcare Pharmacy (UHCP), $15 Copay per prescription Tier 1 $30 Copay per prescription Tier 2 $60 Copay per prescription Tier 3 up to a 30-day supply per prescription 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).	No Benefits

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	100% of Allowed Amount	100% of Allowed Amount not subject to Deductible
Durable Medical Equipment	Allowed Amount	Allowed Amount after Deductible
Consultant Physician Fees	$25 Copay per visit Allowed Amount	$25 Copay per visit Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Allowed Amount	Allowed Amount after Deductible
Dental Treatment Benefits paid for removal of impacted wisdom teeth only.	Allowed Amount	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Mental Illness Treatment See also Benefits for Gender Affirming Care for Gender Dysphoria	**Inpatient:** $250 Copay per Hospital Confinement Allowed Amount **Outpatient office visits:** $25 Copay per visit 100% of Allowed Amount **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount	**Inpatient:** Allowed Amount not subject to Deductible **Outpatient office visits:** $25 Copay per visit Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Substance Use Disorder Treatment	**Inpatient:** $250 Copay per Hospital Confinement Allowed Amount **Outpatient office visits:** $25 Copay per visit 100% of Allowed Amount **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount	**Inpatient:** Allowed Amount not subject to Deductible **Outpatient office visits:** $25 Copay per visit Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	Allowed Amount	Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. See also Benefits for Preventive Health Care Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	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	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Allowed Amount	Allowed Amount after Deductible
Hospice Care	Allowed Amount	Allowed Amount after Deductible
Inpatient Rehabilitation Facility 60 days maximum per Policy Year	$250 Copay per Hospital Confinement Allowed Amount	Allowed Amount not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Skilled Nursing Facility 100 days maximum per Policy Year	Allowed Amount	Allowed Amount after Deductible
Urgent Care Center	$35 Copay per visit 100% of Allowed Amount	$35 Copay per visit 100% of Allowed Amount not subject to Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount	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
Infertility See also Benefits for Infertility and Standard Fertility Preservation Services	Paid as any other Sickness	Paid as any other Sickness
TMJ Disorder	Paid as any other Sickness	Paid as any other Sickness
Acupuncture	Allowed Amount	Allowed Amount after Deductible
Sexual Reassignment Surgery	Allowed Amount	Allowed Amount after Deductible
Vision Including Surgical Treatment of Injuries or Illnesses	Paid as any other Sickness	Paid as any other Sickness
Adult Routine Eye Exam Age 19 or older (One exam, per Policy Year for eyeglasses or contact lenses, not both)	$25 Copay per visit 100% of Allowed Amount	Allowed Amount not subject to Deductible
Routine Physical/Well Visit Benefits for services not otherwise covered under Preventive Care Services. Benefits are limited to one Routine Physical or Well Visit per Policy Year.	Allowed Amount	50% of Allowed Amount not subject to Deductible
Routine Lipid Panel Benefits are limited to one per Policy Year.	100% of Allowed Amount	50% of Allowed Amount not subject to Deductible

Notice of Non-Discrimination

We[1] comply with the applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.
We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

If you need these services, call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans (TTY 711).

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

If you need help with your complaint, please call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans. (TTY 711).
You can also file a complaint with the U.S. Dept. of Health and Human Services, Office for Civil Rights:

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Phone: Toll-free **1-800-368-1019, 1-800-537-7697 (TDD)**
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at: https://www.uhc.com/content/dam/uhcdotcom/en/npp/NDN-LA-UHC-StudentResources-EN.pdf

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "We" refers to the following entities: Dental Benefit Providers, Inc.; Health Allies, Inc.; Spectera, Inc.; UMR, Inc.; United Behavioral Health,; United Behavioral Health of New York, I.P.A.; UnitedHealthcare Insurance Company; and UnitedHealthcare Insurance Company of New York. Please note that not all entities listed are covered by this Notice.

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS

ATTENTION: You can get an interpreter to talk to your doctor at the time of your appointment or with us. If you speak English, free language assistance services and free communications in other formats, such as large print, are available to you. Call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans, or call the toll-free phone number listed on your ID card. (TTY: 711).

ትኩረት፡- በቀጠሮዎ ጊዜ ወይም ከእኛ ጋር ሲሆኑ ከሐኪምዎ ጋር ለመነጋገር አስተርጓሚ ማግኘት ይችላሉ። **አማርኛ (Amharic)** የሚናገሩ ከሆነ፣ ነፃ የቋንቋ ድጋፍ አገልግሎቶች እና ነፃ ግንኙነቶች እንደ ትልቅ ህትመት ባሉ ሌሎች ቅርጸቶች ለእርስዎ ይገኛሉ። ለህክምና ዕቅዶች ወደ **1-866-260-2723**፣ ለእይታ ዕቅዶች ወደ **1-800-638-3120**፣ ለጥርስ ዕቅዶች ወደ **1-877-816-3596** ይደውሉ ወይም በአባል መታወቂያ ካርድዎ ላይ ወደተዘረዘረው ነፃ የስልክ ቁጥር ይደውሉ። (TTY: 711)።

يرجى الانتباه: يمكنك الحصول على مترجم فوري لمساعدتك في التحدث مع طبيبك خلال الموعد أو معنا. إذا كنت تتحدث **اللغة العربية (Arabic)**، ستتوفر لك خدمات المساعدة اللغوية المجانية والمراسلات المجانية بتنسيقات أخرى، مثل الطباعة بأحرف كبيرة. اتصل على **1-866-260-2723** للخطط الطبية، أو **1-800-638-3120** لخطط رعاية البصر، أو **1-877-816-3596** لخطط الأسنان، أو اتصل برقم الهاتف المجاني المدرج على بطاقة هوية العضو الخاصة بك. (TTY: 711)

মনোযোগ দিয়ে শুনুন: আপনার অ্যাপয়েন্টমেন্টের সময় আপনার ডাক্তারের সাথে কথা বলার জন্য বা আমাদের সাথে কথা বলার জন্য আপনি একজন দোভাষী পেতে পারেন। আপনি যদি **বাংলা (Bengali)** এ কথা বলেন, তাহলে বিনামূল্যের ভাষা সহায়তা পরিষেবা এবং অন্যান্য বিনামূল্যের বিভিন্ন যোগাযোগ পদ্ধতি, যেমন বড় মুদ্রণ, আপনার জন্য উপলব্ধ থাকবে। মেডিকেল প্ল্যানের জন্য কল করুন **1-866-260-2723** নম্বরে, ভিশন প্ল্যানের জন্য কল করুন **1-800-638-3120** নম্বরে, ডেন্টাল প্ল্যানের জন্য কল করুন **1-877-816-3596** নম্বরে, অথবা আপনার সদস্য আইডি কার্ডে টোল-ফ্রি ফোন নম্বরে কল করুন। (TTY: 711)

ចំណាំ៖ អ្នកអាចស្នើសុំអ្នកបកប្រែ ដើម្បីទំនាក់ទំនងជាមួយគ្រូពេទ្យរបស់អ្នក នៅពេលណាត់ជួប ឬនិយាយជាមួយយើងខ្ញុំ។ បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Cambodian Mon-Khmer)** មានសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ការទំនាក់ទំនងដោយឥតគិតថ្លៃ ក្នុងទម្រង់ផ្សេងទៀត ដូចជាអក្សរធំ មានសម្រាប់អ្នក។ សូមហៅទូរស័ព្ទទៅ **1-866-260-2723** សម្រាប់ការគ្រោងផែនការ **1-800-638-3120** សម្រាប់ការគ្រោងថែទាំភ្នែក **1-877-816-3596** សម្រាប់ការគ្រោងថែទាំធ្មេញ ឬហៅទូរស័ព្ទទៅលេខទូរស័ព្ទដោយមិនគិតថ្លៃ ដែលបានចុះក្នុងបណ្ណសម្គាល់ខ្លួនរបស់អ្នក។ (TTY៖ 711)។

ATENSHUN: Kuŋka me liye ayu yo interprete para ughul maghal na dokto ya eppunghi me guahu. Gare kapetal **Faluwasch (Carolinian)**, ye toore paliuwal kapetal Faluwasch lane bwe me sew format, ta tipel lane, bwe bwale tepangiyom. Kali **1-866-260-2723** para ughul Lalap ni ughul tipiye, **1-800-638-3120** para ughul Lalap ni tipiye nu mata, **1-877-816-3596** para ughul Lalap ni tipiye nu apapa, o kali ewe kali rerekkepal ni Nuumur ni telepon yeeg listed me ni Kaaret ni meybur ID-mu. (TTY: 711).

ATENSYON: Siña hao humosga un intérprete para kumuentos yan i doktermu gi ora di i konsulta-mu pat yan hame. Yanggen fifino' hao **CHamoru (Chamorro)**, guaha setbisio siha para hågu ni' mandibåtdi, i setbision fino' pat lengguåhi yan fina'uma'espiha gi otro na manera siha, taiguihi i para mana'dångkolo i inemprenta. Kålle **1-866-260-2723** para Planån Mediku, **1-800-638-3120** para Planån Visión, **1-877-816-3596** para Planån Dental, pat kålle i númeru gratut na teleponu na esta på'go gi kåtta ID para miembro -mu. (TTY: 711).

請注意：您可以獲得一位口譯員，在您看診時與您的醫生溝通或平常與我們溝通。如果您說**中文 (Chinese)**，我們可為您提供免費的語言協助服務與其他溝通格式，例如大字版文件。醫療計劃請致電**1-866-260-2723**，視力計劃請致電**1-800-638-3120**，牙科計劃請致電 **1-877-816-3596**，或撥打您會員卡上所列的免付費電話號碼。(TTY：711) 。

توجه: شما می‌توانید یک مترجم برای صحبت با پزشک خود در زمان ویزیت یا برای گفتگو با ما، درخواست کنید. اگر **فارسی (Farsi)**، صحبت می‌کنید، خدمات رایگان کمک زبانی و خدمات رایگان ارتباطاتی در سایر قالب‌ها، مانند چاپ با حروف درشت، در دسترس شما هستند. برای برنامه‌های پزشکی با شماره **1-866-260-2723** و برای طرح چشم پزشکی با شماره **1-800-638-3120** و برای طرح دندانپزشکی با شماره **1-877-816-3596**، یا با (TTY: 711). اگر به کمک بیشتری نیاز دارید، با خط تلفن رایگان سازمان

ATTENTION : Vous pouvez demander à un(e) interprète de parler à votre médecin au moment de votre rendez-vous ou avec nous. Si vous parlez **français (French)**, des services d'assistance linguistique et des communications dans d'autres formats, notamment en gros caractères, sont mis à votre disposition gratuitement. Appelez le **1-866-260-2723** pour les régimes médicaux, le **1-800-638-3120** pour les régimes de soins de la vue, le **1-877-816-3596** pour les régimes de soins dentaires, ou appelez le numéro de téléphone gratuit indiqué sur votre carte de membre. (TTY : 711).

ACHTUNG: Sie können für Gespräche mit Ihrem Arzt bei Ihrem Termin oder mit uns einen Dolmetscher anfordern. Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und kostenlose Kommunikation in anderen Formaten, wie zum Beispiel große Schrift, zur Verfügung. Rufen Sie **1-866-260-2723** für Krankenversicherungen, **1-800-638-3120** für Augenversicherungen, **1-877-816-3596** für Zahnversicherungen oder die gebührenfreie Telefonnummer auf Ihrer Mitgliedskarte an. (TTY: 711).

ΠΡΟΣΟΧΗ: Μπορείτε να πάρετε έναν διερμηνέα για να μιλήσετε με το γιατρό σας στο ραντεβού σας ή για να μιλήσετε μαζί μας. Εάν μιλάτε **Ελληνικά (Greek)**, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες γλωσσικής βοήθειας και δωρεάν επικοινωνία σε άλλες μορφοποιήσεις, όπως μεγάλα γράμματα. Καλέστε στο **1-866-260-2723** για ιατρικά προγράμματα, στο **1-800-638-3120** για οφθαλμολογικά προγράμματα, στο **1-877-816-3596** για οδοντιατρικά προγράμματα ή καλέστε τον αριθμό τηλεφώνου χωρίς χρέωση που αναγράφεται στην κάρτα μέλους σας. (TTY: 711).

ધ્યાન આપો: તમે તમારી મુલાકાત સમયે અથવા અમારી સાથે તમારા ડૉક્ટર સાથે વાત કરવા માટે દુભાષિયા મેળવી શકો છો. જો તમે ગુજરાતી **(Gujarati)**, બોલો છો, તો મફત ભાષા સહાયતા સેવાઓ અને અન્ય ફોર્મેટમાં મફત સંચાર, જેમ કે મોટી પ્રિન્ટ, તમારા માટે ઉપલબ્ધ છે. મેડિકલ પ્લાન માટે **1-866-260-2723**, વિઝન પ્લાન માટે **1-800-638-3120**, ડેન્ટલ પ્લાન માટે **1-877-816-3596** પર કૉલ કરો અથવા તમારા સભ્ય આઈડી કાર્ડ પર સૂચિબદ્ધ ટોલ-ફ્રી ફોન નંબર પર કૉલ કરો. (TTY: 711).

ATANSYON: Ou ka jwenn yon entèprèt pou pale ak doktè ou a nan moman randevou w la oswa avèk nou. Si w pale **Kreyòl Ayisyen (Haitian Creole)**, sèvis asistans lang gratis ak kominikasyon gratis nan lòt fòma, tankou gwo lèt, disponib pou ou. Rele **1-866-260-2723** pou Plan Medikal, **1-800-638-3120** pou Plan Vizyon, **1-877-816-3596** pou Plan Dantè, oswa rele nimewo telefòn gratis ki endike sou kat ID manm ou a. (TTY: 711).

ध्यान दें: आप अपनी अपॉइंटमेंट के समय या हमारे साथ अपने डॉक्टर से बात करने के लिए एक दुभाषिया प्राप्त कर सकते हैं। यदि आप **हिन्दी (Hindi)** बोलते हैं, तो मुफ्त भाषा सहायता सेवाएँ और बड़े प्रिंट जैसे अन्य प्रारूपों में मुफ्त संचार सेवा आपके लिए उपलब्ध हैं। मेडिकल प्लान के लिए **1-866-260-2723** पर कॉल करें, विजन प्लान के लिए **1-800-638-3120** पर, डेंटल प्लान के लिए **1-877-816-3596** पर कॉल करें, या अपने सदस्य आईडी कार्ड पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें। (TTY: 711)

CEEB TOOM: Koj tuaj yeem tau txais ib tug neeg txhais lus tham nrog koj tus kws kho mob thaum lub sijhawm kev teem caij los sis thaum tham nrog peb. Yog tias koj hais **Lus Hmoob (Hmong)**, yuav muaj cov kev pab cuam txhais lus pub dawb thiab kev sib txuas lus ua lwm hom qauv, xws li luam ua tus ntawv loj rau koj. Hu rau **1-866-260-2723** rau Cov Phiaj Xwm Kho Mob, **1-800-638-3120** rau Cov Phiaj Xwm Kho Qhov Muag, **1-877-816-3596** rau Cov Phiaj Xwm Kho Hniav, los yog hu rau tus xov tooj hu dawb uas teev rau hauv koj daim npav ID. (TTY: 711).

ATENSION: Makaalaka iti interpreter a makisarita kadakami wenno iti doktormo iti oras ti appointment-mo. No makasaoka iti **Ilocano (Ilocano)**, makaalaka iti libre a tulong iti lengguahe ken libre a pannakikomunikar iti sabali a format, kas iti dadakkel a letra. Tawagam ti **1-866-260-2723** para kadagiti Plan a Medikal, **1-800-638-3120** para kadagiti Plan para iti Panagkita, **1-877-816-3596** para kadagiti Plan para iti Ngipen, wenno tawagam ti libre a numero ti telepono a nailista iti ID card-mo kas miembro. (TTY: 711).

ATTENZIONE: il giorno del Suo appuntamento, può richiedere i servizi di un interprete per parlare con il Suo medico o con noi. Se parla **italiano (Italian)**, sono disponibili gratuitamente servizi di assistenza linguistica e comunicazioni in altri formati, come la stampa a caratteri grandi. Chiami il numero **1-866-260-2723** per i piani sanitari, il numero **1-800-638-3120** per i piani oculistici e il numero **1-877-816-3596** per i piani dentistici, oppure chiami il numero verde riportato sul Suo tesserino identificativo. (TTY: 711).

ご注意：ご予約にお越しの際またはご来院の際、医師とお話になるための通訳者を手配することが可能です。あなたが**日本語 (Japanese)** をお話になる場合、無料の言語支援サービスおよび大きい活字など他の形式による無料のコミュニケーションをご利用になれます。医療プランについては **1-866-260-2723**、眼科プランについては **1-800-638-3120**、歯科プランについては **1-877-816-3596** までお電話いただくか、メンバー ID カードに記載の通話料無料の番号までお電話ください。(TTY: 711)。

주의: 진료 시 의사와 상담하거나 저희와의 소통을 위해 통역사 서비스를 받으실 수 있습니다. **한국어(Korean)**를 사용하시는 경우 무료 언어 지원 서비스와 큰 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 의료 플랜의 경우 **1-866-260-2723**, 안과 플랜의 경우 **1-800-638-3120**, 치과 플랜의 경우 **1-877-816-3596**번으로 전화하거나 귀하의 회원 ID 카드에 기재된 무료 전화번호로 전화하십시오. (TTY: 711).

ຊາບໄວ้ດວກ: ທ່ານສາມາດຂໍນາຍແປພາສາເພື່ອເວົ້າກັບທ່ານໝໍໃນເວລາທີ່ທ່ານນັດໝາຍ ຫຼື ກັບພວກເຮົາໄດ້. ຖ້າວ່າທ່ານເວົ້າ **ພາສາລາວ (Lao)**, ການບໍ່ເສຍຄ່າການຊ່ວຍເຫຼືອດ້ານ ພາສາ ແລະ ການສື່ສານຜູ້ເຈັບປ່ວຍໃນຮູບແບບອື່ນໆ, ເຊັ່ນ: ການພິມຂະໜາດ ໃຫຍ່, ແມ່ນມີໃຫ້ທ່ານ. ໂທ **1-866-260-2723** ສໍາລັບແຜນການທາງການແພດ, **1-800-638-3120** ສໍາລັບແຜນການທາງສາຍຕາ, **1-877-816-3596** ສໍາລັບແຜນການທາງແຂ້ວ, ຫຼື ໂທຫາເບີໂທຟຣີທີ່ລະບຸໄວ້ໃນບັດປະຈໍາຕົວສະມາຊິກຂອງທ່ານ.(TTY: 711).

SHOOH: Nánihoot'áaní góne' ne'azee' íił'íní bich'į' yániłti' doodago nihí nihich'į' yániłti'go ata' halne'í ła' naayíłt'eehgo bíighah. **Diné (Navajo)** bizaad bee yániłti'to, t'áá jiik'eh saad bee áka'e'eyeed bee áka'anída'ow'í dóó t'áá jíík'eh nááná łahgo át'éego bee hada'dilyaaígíí bee ahił hane', díí nitsaago bik'e'ashchíní, ná dahólǫ. Ats'íís Nánél'ǫ́ǫ́h Bee Hada'dít'éhí biniiyé kohjį' **1-866-260-2723** hodíilnih, Anáá' Bee Hoot'íní Bee Hada'dít'éhí biniiyé kohjį' **1-800-638-3120** hodíilnih, Awoo' Bee Hada'dít'éhí biniiyé kóhjį' **1-877-816-3596** hodíilnih, doodago bee nił ha'dít'éhí ninaaltsoos nitł'izí bee nééhóziní ID bąąh t'áá jiik'eh námboo bee dahane'í biká'ígíí bee hodíilnih. (TTY: 711).

ध्यान दिनुहोस्: तपाईंले आफ्नो अपोइन्टमेन्टको समयमा वा हामीसँग आफ्नो डाक्टरसँग कुरा गर्न दोभाषे लिन सक्नुहुन्छ। तपाईं **नेपाली (Nepali)** बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू र ठूलो अक्षर जस्ता अन्य ढाँचाहरूमा निःशुल्क सञ्चार सेवाहरू तपाईंको लागि उपलब्ध छन्। चिकित्सा योजनाहरूको लागि **1-866-260-2723** भिजन योजनाहरूको लागि **1-800-638-3120** दन्त योजनाहरूको लागि **1-877-816-3596** मा कल गर्नुहोस्, वा तपाईंको सदस्य परिचयपत्रमा सूचीबद्ध टोल-फ्री फोन नम्बरमा कल गर्नुहोस्। (TTY: 711)

WICHDICH: Du darfscht en Interpreter griege fer schwetze mit dei Dokter an dei Appointment odder mit uns. Wann du **Deitsch (Pennsylvania Dutch)** schwetzscht un brauchscht Hilf fer communicat-e, kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Call **1-866-260-2723** fer Plans as zu duh hen mit Dokteres, **1-800-638-3120** fer Plans as zu duh hen mit Sehne, **1-877-816-3596** fer Plans as zu duh hen mit Zaeh, odder call die Toll-Free Phone Number as uff dei ID Card is. (TTY: 711).

UWAGA: Możesz poprosić tłumacza o pomoc w rozmowie z lekarzem w czasie wizyty lub z nami. Osoby mówiące w języku **polskim (Polish)**, mają dostęp do bezpłatnej usługi pomocy językowej i bezpłatnej komunikacji w innych formatach, takich jak duży druk. Zadzwoń pod numer **1-866-260-2723** w celu uzyskania informacji o planach medycznych, **1-800-638-3120** o planach okulistycznych, **1-877-816-3596** o planach stomatologicznych lub zadzwoń pod bezpłatny numer telefonu podany na karcie członkowskiej. (TTY: 711).

ATENÇÃO: Você pode ter um intérprete para falar com o médico no momento da consulta ou conosco. Se você fala **português (Portuguese)**, há serviços gratuitos de assistência linguística e comunicações gratuitas em outros formatos, como letras grandes, disponíveis para você. Ligue para **1-866-260-2723** para planos médicos, **1-800-638-3120** para planos oftalmológicos, **1-877-816-3596** para planos odontológicos ou ligue para o número de telefone gratuito listado no seu cartão de ID de membro. (TTY: 711).

ਧਿਆਨ ਦਿਓ: ਤੁਸੀਂ ਆਪਣੀ ਅਪਾਇੰਟਮੈਂਟ ਦੇ ਸਮੇਂ ਆਪਣੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਸਾਡੇ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਜੇਕਰ ਤੁਸੀਂ **ਪੰਜਾਬੀ (Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਹੋਰ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਮੁਫ਼ਤ ਸੰਚਾਰ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿੱਚ, ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹਨ। ਮੈਡੀਕਲ ਯੋਜਨਾਵਾਂ ਲਈ **1-866-260-2723**, ਵਿਜ਼ਨ ਯੋਜਨਾਵਾਂ ਲਈ **1-800-638-3120**, ਡੈਂਟਲ ਯੋਜਨਾਵਾਂ ਲਈ **1-877-816-3596** 'ਤੇ ਕਾਲ ਕਰੋ, ਜਾਂ ਆਪਣੇ ਮੈਂਬਰ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਸੂਚੀਬੱਧ ਟੋਲ-ਫ੍ਰੀ ਫ਼ੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ। (TTY: 711)

ВНИМАНИЕ! Вы можете воспользоваться услугами устного переводчика для общения с вашим врачом во время приема или через наши услуги. Если вы говорите на **русском** языке **(Russian)**, вам доступны бесплатные услуги языковой поддержки и бесплатные материалы в других форматах, например, напечатанные крупным шрифтом. Позвоните по телефону **1-866-260-2723** для медицинских планов, **1-800-638-3120** для планов по охране зрения, **1-877-816-3596** для планов по стоматологическим услугам или на линию для бесплатного звонка, указанную на вашей идентификационной карточке участника. (Линия TTY: 711).

FA'AALIGA: Afai e te tautala i le **Faa-Samoa (Samoan)**, o lo'o avanoa mo oe 'au'aunaga fesoasoani tau gagana e leai se totogi ma feso'ota'iga e leai se totogi i isi faiga, e pei o lomiga e lapopo'a mata'itusi. Vala'au **1-866-260-2723** mo Fuafuaga Fa'afoma'i, **1-800-638-3120** mo Fuafuaga Va'ai, **1-877-816-3596** mo Fuafuaga Nifo, pe vala'au le numera telefoni e leai se totogi o lo'o lisiina i luga o lau pepa ID tagata. (TTY: 711).

FIIRO GAAR AH: Waxaad heli kartaa turjumaan si aad ula hadasho dhakhtarkaaga wakhtiga ballanta ama annaga. Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda bilaashka ah iyo isgaarsiino bilaash ah oo qaabab kale ah, sida far waaweyn, ayaa diyaar kuu ah. Wac **1-866-260-2723** wixii ah Qorshayaasha Caafimaadka, **1-800-638-3120** Qorshooyinka Aragtida, **1-877-816-3596** wixii ah Qorshooyinka Ilkaha, ama wac lambarka telefoonka bilaashka ah ee ku qoran kaarka aqoonsiga xubinta. (TTY: 711).

ATENCIÓN: Puede conseguir un intérprete para hablar con nosotros o con su médico durante su cita. Si usted habla **español (Spanish)**, tiene a su disposición servicios gratuitos de asistencia en otros idiomas y comunicaciones gratuitas en otros formatos, como letra grande. Llame al **1-866-260-2723** para los planes médicos, al **1-800-638-3120** para los planes de la vista y al **1-877-816-3596** para los planes dentales, o llame al número de teléfono gratuito que aparece en su tarjeta de identificación de membresía. (TTY: 711).

PAUNAWA: Maaari kang makakuha ng interpreter upang makausap ang iyong doktor sa panahon ng iyong appointment o sa pakikipag-usap sa amin. Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika at libreng komunikasyon sa ibang mga format, tulad ng malalaking print. Tumawag sa **1-866-260-2723** para sa Mga Planong Medikal, **1-800-638-3120** para sa Mga Plano para sa Paningin, **1-877-816-3596** para sa Mga Plano para sa Ngipin, o tumawag nang libre sa numero ng telepono na nakalista sa iyong ID card ng miyembro. (TTY: 711).

หมายเหตุ: คุณสามารถขอล่ามมาพูดคุยกับแพทย์ของคุณได้ในเวลาที่คุณนัดหมายหรือกับเรา หากคุณพูดภาษาไทย **(Thai)** เรายินดีให้บริการช่วยเหลือด้านภาษาและการสื่อสารในรูปแบบอื่นๆ เช่น การพิมพ์ด้วยตัวอักษรขนาดใหญ่โดยไม่คิดค่าใช้จ่าย โทร **1-866-260-2723** สำหรับการวางแผนทางการแพทย์ **1-800-638-3120** สำหรับการวางแผนด้านจักษุ **1-877-816-3596** สำหรับการวางแผนด้านทันตกรรม หรือโทรไปยังหมายเลขโทรศัพท์ที่ระบุไว้ในบัตรประจำตัวสมาชิกของคุณ (TTY: 711)

ЗВЕРНІТЬ УВАГУ! Під час прийому у лікаря або розмови з нами ви маєте змогу скористатися послугами усного перекладача. Якщо ви розмовляєте **українською (Ukrainian)**, ви можете безоплатно користуватися послугами мовної підтримки, а також безоплатно отримувати інформаційні матеріали в інших форматах, як-от набрані великим шрифтом. Телефонуйте на номер **1-866-260-2723** щодо планів медичного страхування, на номер **1-800-638-3120**, щоб дізнатися докладніше про плани страхового покриття офтальмологічних послуг, на номер **1-877-816-3596**, щоб дізнатися докладніше про плани страхового покриття стоматологічних послуг, або телефонуйте на номер безкоштовної телефонної лінії, зазначений на вашій ідентифікаційній картці учасника. (лінія TTY: 711).

توجہ فرمائیں: آپ اپنی ملاقات کے وقت یا ہمارے ساتھ اپنے ڈاکٹر سے بات کرنے کے لیے مترجم حاصل کر سکتے ہیں۔ اگر آپ **اردو (Urdu)** بولتے ہیں، تو مفت لسانی معاونتی خدمات اور دیگر فارمیٹس مثلاً بڑے پرنٹ میں مفت مواصلات آپ کے لیے دستیاب ہیں۔ میڈیکل پلانز کے لیے **1-866-260-2723** پر، ویژن پلانز کے لیے **1-800-638-3120**، ڈینٹل پلانز کے لیے **1-877-816-3596** پر کال کریں، یا (TTY: 711)

LƯU Ý: Quý vị có thể có một thông dịch viên miễn phí để nói chuyện với bác sĩ trong buổi hẹn khám của mình hoặc nói chuyện với chúng tôi. Nếu quý vị nói **Tiếng Việt (Vietnamese)**, quý vị sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí và các phương tiện trao đổi liên lạc miễn phí ở các định dạng khác, chẳng hạn như bản in chữ lớn. Hãy gọi **1-866-260-2723** cho các Chương trình Y tế, **1-800-638-3120** cho các Chương trình Nhãn khoa, **1-877-816-3596** cho các Chương trình Nha khoa, hoặc gọi số điện thoại miễn phí được ghi trên thẻ ID hội viên của quý vị. (TTY: 711).

POLICY NUMBER: 2025-4059-1

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

NOC1 - 10/22/2025

1. Updated the eligibility per below -

FROM:

All domestic degree-seeking students, regardless of credit hours, must purchase the plan, unless proof of comparable coverage is furnished. Online only degree students are not eligible. All international student (F and J visas), regardless of degree seeking status, are automatically enrolled in this insurance plan unless proof of comparable coverage is furnished.

TO:

All domestic degree-seeking students enrolled in at least one credit hour must purchase the plan, unless proof of comparable coverage is furnished. Online only degree students are not eligible. All international student (F and J visas), regardless of degree seeking status, are automatically enrolled in this insurance plan unless proof of comparable coverage is furnished.