UNITEDHEALTHCARE INSURANCE COMPANY

Home Office Address: 185 Asylum Street, Hartford, CT 06103-3408

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for Students of

DePaul University

2026-2027

This Certificate of Coverage is Part of Policy #2026-394-1

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. 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.

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Introduction

Welcome to the UnitedHealthcare Student Resources Student Health Insurance Plan.

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

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

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

Section 1: Who Is Covered

The Master Policy covers students 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 Undergraduates, Graduates, Law, International Exchange and English Language Academy (ELA) students are required to enroll 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, 2026. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 31, 2027. 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, or as soon as possible after the patient becomes lucid and able to communicate, 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.

Additionally, if an Insured makes a good faith effort to locate a Preferred Provider to obtain a Covered Medical Expense and it is determined the network does not include the appropriate Provider due to insufficient number, type, unreasonable travel distance, or delay, or the Preferred Provider refusing to provide a Covered Medical Expense because it is contrary to the conscience of the Preferred Provider (as protected by the Health Care Right of Conscience Act), the Company shall ensure the Insured is eligible for cost-sharing 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.

No Surprises Act

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 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.
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 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.
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.

DISCLOSURE OF LIMITED BENEFIT

WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED. **THE INSURED CAN EXPECT TO PAY MORE THAN THE COST-SHARING AMOUNT DEFINED IN THE POLICY IN NON-EMERGENCY SITUATIONS.** Except in limited situations governed by the federal No Surprises Act or Section 356z.3a of the Illinois Insurance Code (215 ILCS 5/356z.3a), Out-of-Network Providers furnishing non-emergency services may bill an Insured for any amount up to the billed charge after the plan has paid its portion of the bill. If the Insured elects to use an Out-of-Network Provider, plan benefit payments will be determined according to the Policy’s fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy.

Preferred Providers have agreed to ONLY bill Insureds the cost-sharing amounts. An Insured may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on their identification card.

Continuation of Care
If the Insured is undergoing an active course of treatment from a Preferred Provider at the time the provider is terminated without cause or if a newly Insured Person is undergoing an active course of treatment from a provider who is not a Preferred Provider, the Insured will be allowed to continue treatment at the Preferred Provider benefit level until the treatment is complete or for 90 days, whichever is shorter. An active course of treatment includes:

- An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
- An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the Insured is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.
- Undergoing a course of treatment for pregnancy.
- An ongoing course of treatment for a health condition for which a treating Physician or health care provider attests that discontinuing care by that Physician or healthcare provider would worsen the condition or interfere with anticipated outcomes.

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 or private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

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.

4. **Routine Newborn Care.**
While Hospital Confined and routine nursery care provided from and after the moment of 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 surgery performed in an outpatient setting, including a Physician's office.

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, including chiropractic and osteopathic manipulation.
- 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 Congenital Condition, Injury, or Sickness.

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.

Benefits for Physiotherapy are provided for the treatment of autism spectrum disorders the same as for any other Sickness.

Medically Necessary services will not be denied or refused solely based on location where services are provided.

Physiotherapy benefits are not subject to visit limitations.

See also Benefits for Cleft Lip and Cleft Palate.

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.**
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 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.
- Cardiopulmonary monitors.

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 will be provided for prescribed orally administered cancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

Benefits for prescription topical eye medication will be provided without regard to a coverage restriction for early refill of prescription renewals as long as:
- The medication is used to treat a chronic condition of the eye.
- The refill is requested by the Insured prior to the last day of the prescribed dosage period and after at least 75% of the predicted days of use.
- The prescribing Physician indicates on the original prescription that refills are permitted and that the early refills requested by the Insured do not exceed the total number of refills prescribed.

Benefits will be provided for intranasal opioid reversal agent prescriptions for initial prescriptions of opioids with dosages of 50 MME or higher.

Benefits for Buprenorphine products or brand equivalent products for medically assisted treatment of opioid use disorder shall not require Prior Authorization, dispensing limits, fail first policies, or lifetime limit requirements.

Benefits will be provided for topical anti-inflammatory prescription medications for acute and chronic pain.

Benefits will be provided for early refills for prescription inhalers, including meter-dose inhalers, nebulizers, and dry powder inhalers, for Insureds suffering from asthma or other life-threatening bronchial ailments.

Benefits will be provided for epinephrine injectors including an auto-injector and a pre-filled syringe approved by the FDA and used for the administration of epinephrine.

Benefits will be provided for Medically Necessary vaginal estrogen or its therapeutic equivalent. Benefits will not exceed the cost sharing requirements imposed on Prescription Drug Products for the treatment of erectile dysfunction.

See also Benefits for Opioid Antagonists.

See also Benefits for Abortifacients and Hormonal Medication, Pre-exposure and Post-exposure Prophylaxis.

Other

25. **Ambulance Services.**
Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital for Medical Emergency treatment.

Non-emergency Medically Necessary ambulance transportation by a licensed ambulance service between facilities when the transportation meets one of the following:

- From an Out-of-Network Hospital to the closest Preferred Provider Hospital when Covered Medical Expenses are required.
- To the closest Preferred Provider Hospital that provides the required Covered Medical Expenses that were not available at the original Hospital.
- From an Urgent Care Facility or Inpatient facility to another Inpatient facility where the required Covered Medical Expenses can be received.

26. **Durable Medical Equipment.**

Durable Medical Equipment must be all of the following:

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

For the purposes of this benefit, the following are considered durable medical equipment.

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

Benefits are provided only for external prosthetic devices and do not include any device that is fully implanted into the body. Internal prosthetics are a Covered Medical Expense for which benefits are available under the applicable medical/surgical Covered Medical Expense categories in this Certificate.

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

See also Benefits for Customized Orthotic Devices.

See also Benefits for Cleft Lip and Cleft Palate.

27. **Consultant Physician Fees.**

Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**

Dental treatment when services are performed by a Physician or dentist and limited to the following:

- Injury to Sound, Natural Teeth.
- Surgical removal of complete bony impacted 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. **Gender Dysphoria Treatment.**

Benefits for the Medically Necessary treatment of Gender Dysphoria provided by or under the direction of a Physician.

For the purpose of this benefit, "gender dysphoria" means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

30. **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.

Treatment for Inpatient Mental Illness may be reviewed retrospectively. If denied retrospectively, the Insured will not be liable, other than for the applicable Deductible, Copayment, or Coinsurance, for treatment through the date the Adverse Determination is issued. Coverage will not be retrospectively denied for the first 72 hours of treatment for Inpatient Mental Illness treatment, 48 hours for partial hospitalization, and two business days for outpatient Mental Illness treatment except upon:

- Reasonable determination that the inpatient Mental Illness treatment was not provided.
- Determination that the Insured receiving the treatment is not an Insured Person under the Policy.
- Material misrepresentation by the Insured or Physician.
- Determination that a service was excluded under the terms of coverage. In that case, the Insured will be liable for all services.
- Determination that the Mental Illness treatment was not Medically Necessary.
- Determination that the Insured did not consent to the treatment and that there was no court order mandating the treatment.

Benefits will be paid for tele-psychiatry visits on the same basis as an in-person office visit.

See also Benefits for Mental Health and Wellness Visits.

See also Benefits for Treatment Models for Early Treatment of Serious Mental Illness.

31. **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.

Treatment for Inpatient Substance Use Disorder treatment may be reviewed retrospectively. If denied retrospectively, the Insured will not be liable, other than for the applicable Deductible, Copayment, or Coinsurance, for treatment through the date the Adverse Determination is issued. Coverage will not be retrospectively denied for the first 72 hours of treatment for Inpatient Substance Use Disorder treatment, 48 hours for partial hospitalization, and two business days for outpatient Substance Use Disorder treatment except upon:

- Reasonable determination that the inpatient Substance Use Disorder treatment was not provided.
- Determination that the Insured receiving the treatment is not an Insured Person under the Policy.
- Material misrepresentation by the Insured or Physician.
- Determination that a service was excluded under the terms of coverage. In that case, the Insured will be liable for all services.
- Determination that the Substance Use Disorder treatment was not Medically Necessary.
- Determination that the Insured did not consent to the treatment and that there was no court order mandating the treatment.

Benefits include opioid medically assisted treatment (MAT). Benefits will be paid for tele-psychiatry visits on the same basis as an in-person office visit.

32. **Maternity.**

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

Benefits include two at-home, urine-based pregnancy tests every 30 days.

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 you are experiencing a high-risk pregnancy, a case management program is available to assist you during your pregnancy to help coordinate and assure continuity of services, including, but not limited to, health services, social services, and educational services. The case management program is an active and collaborative process involving a single qualified case manager, the Insured, the Insured's family, the Physicians, and the community. This includes close coordination and involvement with all service providers in the management plan for that Insured or family, including assuring that the Insured the services. Case management involves:

1. Individualized assessment of needs.

2. Planning services.
3. Referral, monitoring, and advocacy to assist an Insured in gaining access to appropriate services.
4. Closure when services are no longer required.

The Insured may contact the Company at 1-800-767-0700 for additional information.

For the purpose of this benefit, a high-risk pregnancy means a pregnancy in which the pregnant or postpartum Insured or baby is at an increased risk for poor health or complications during pregnancy or childbirth, including but not limited to, hypertension disorders, gestational diabetes, and hemorrhage.

Benefits include pregnancy, postpartum, and newborn care rendered by perinatal doulas or licensed certified professional midwives including:

- Services for home births.
- Home visits.
- Support during labor, abortion, or miscarriage.
- Necessary equipment and medical supplies for a home birth.

Home visits by a perinatal doula are limited to 16 visits before and 16 visits after a birth, miscarriage, or abortion up to $8,000 for each pregnancy and postpartum period.

Benefits will be paid for postpartum services received within the first 12 months after the pregnancy ends.

Benefits shall also include home visits by Lactation Consultants and the purchase of breast pump and breast pump supplies, including breastfeeding supplies and feeding aids as recommended by the Lactation Consultant.

“Lactation consultant” means an International Board-Certified Lactation Consultant, a certified lactation specialist with a certification from Lactation Education Consultants, or a certified lactation counselor as defined in subsection (a) of Section 5-18.10 of the Illinois Public Aid Code.

Benefits include prenatal HIV testing when ordered by an attending Physician, a physician assistant, or an advanced practice registered nurse. Orders must be consistent with the recommendations of the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. An earlier discharge may be provided if based on evaluation and availability of a post-discharge Physician office visit or an in-home nurse visit to verify the condition of the newborn in the first 48 hours after discharge. A shorter length stay must meet the protocols and guidelines for the length of a Hospital Inpatient stay as developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics.

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

34. **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.
- Immunizations and medical countermeasures that have in effect a recommendation within the State Guidelines for Communicable Disease Prevention issued by the Director of Public Health.

Required preventive care services are updated on an ongoing basis as guidelines and recommendations change. The complete and current list of preventive care services covered under the health reform law can be found at: https://www.healthcare.gov/preventive-care-benefits/ and https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Current preventive care services are listed below.

An exception process may apply to certain categories of preventive care services if the Insured's Physician determines that an alternative preventive care service is Medically Necessary for the Insured.

An expedited exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to the Insured's health.

To request an exception, the Insured's Physician must fill out an exception request form with the appropriate clinical information and attest that the requested preventive care service is Medically Necessary for the Insured.

If the Company approves the request for an exception, benefits for the services will be provided the same as a preventive care service.

For more information and to access the exception request form, please visit www.uhcprovider.com then go to *Resource Library and Provider Forms (Commercial Plans).* For questions, call the telephone number shown on your ID card.

Preventive care services for adults:

- Abdominal aortic aneurysm one-time screening for men age 65 to 75 who have ever smoked.
- Alcohol misuse screening and counseling.
- Anxiety screening for adults age 64 years or younger, including pregnant and postpartum adults.
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults age 50 to 59 with a high cardiovascular risk.
- Behavioral counseling to promote a healthy diet and physical activity for adults age 18 and older who are at high risk of cardiovascular disease.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults age 45 to 85 or as prescribed by a Physician.
- Depression screening for adults.
- Diabetes (Type 2) and prediabetes screening for adults 35 to 70 years who are overweight or obese.
- Diet/nutrition counseling for adults at higher risk for chronic disease.
- Falls prevention with exercise interventions for adults over 65, living in a community setting.
- Hepatitis B screening for people at high risk, including people from countries with 2 % or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- Hepatitis C screening for adults age 18 to 79.
- Herpes zoster (shingles) vaccine for adults age 60 and older.
- HIV screening for everyone ages 15 to 65, and other ages at increased risk.
- Human papillomavirus (HPV) vaccine.
- Immunization vaccines for adults – doses, recommended ages and recommended populations vary.
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.
- Obesity screening and counseling for all adults.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use.
- Screening for unhealthy drug use in adults age 18 and older. Screening includes asking questions about unhealthy drug use, not testing of biological specimens.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Skin cancer behavioral counseling up to age 24 for adults with fair skin types.
- Statin preventive medication for adults 40 to 75 at high risk.
- Syphilis screening for all adults at higher risk for infection.
- Tobacco use screening and counseling for all adults and cessation interventions (including nicotine patches and gum when obtained with a prescription) for tobacco users.
- Tuberculosis screening for certain adults without symptoms at high risk.

Preventive care services for women:

- Anemia screening on a routine basis for pregnant women.
- Anxiety screening for pregnant and postpartum women.

- Behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause.
- Breast cancer risk assessment genetic testing, and counseling (BRCA) for women at higher risk for breast cancer.
- Breast cancer mammography screenings every 2 years for women 40 to 74.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies and equipment, for pregnant and nursing women. Breast pumps are limited to one pump per pregnancy.
- Cervical cancer screening for women age 21 to 65.
- Chlamydia infection screening for all pregnant women, younger women, and other women at higher risk of infection.
- Contraception: Food and Drug Administration-approved contraceptive methods (including long acting reversible contraceptive devices), sterilization procedures, and patient education and counseling, as prescribed by a Physician for women with reproductive capacity (not including abortifacient drugs).
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
- Domestic, intimate partner, and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 weeks pregnant or later and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all pregnant women, younger women, and other women at higher risk of infection.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for everyone age 15 to 65 and other ages at increased risk.
- HIV Screening for pregnant women.
- Hypertensive disorder screenings with blood pressure measurements throughout pregnancy.
- Low dose aspirin after 12 weeks gestation for women who are at high risk for preeclampsia.
- Maternal depression screening for mothers at well-baby visits.
- Osteoporosis screening with bone measurement for women age 65 and older.
- Osteoporosis screening with bone measurement in postmenopausal women younger than 65 who are at increased risk of osteoporosis.
- Preeclampsia prevention and screening for pregnant women with high blood pressure.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Sexually transmitted infections screening and counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk for infection.
- Tobacco use screening and interventions for all women, and expanded intervention and counseling for pregnant tobacco users.
- Urinary incontinence screening.
- Urinary tract or other infection screening for pregnant women.
- Well-woman visits to get recommended services.

Preventive care services for children:

- Alcohol, tobacco, and drug use assessments for adolescents.
- Anxiety screening for children and adolescents age 8 to 18 years.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Bilirubin concentration screening for newborns.
- Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood screening for newborns.
- Depression screening for adolescents beginning routinely at age 12.
- Developmental screening for children under age 3.
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders.

- Fluoride supplements beginning at age 6 months for children without fluoride in their water source.
- Fluoride varnish for all infants and children as soon as teeth are present.
- Gonorrhea prevention medication for the eyes of all newborns.
- Hearing screening for all newborns and regular screenings for children and adolescents as recommended by their Physician.
- Height, weight and body mass index (BMI) measurements taken regularly for all children.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for adolescents at higher risk.
- HIV screening for adolescents at higher risk.
- Human papillomavirus (HPV) vaccine.
- Hypothyroidism screening for newborns.
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary.
- Intimate partner violence screening.
- Lead screening for children at risk of exposure.
- Obesity screening and counseling for children and adolescents age 6 and older and intensive behavioral interventions to promote improvement in weight status.
- Oral health risk assessment for young children from ages: 6 months to 6 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use.
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- Skin cancer behavioral counseling for ages 6 months to 24 years with fair skin types.
- Syphilis screening for adolescents who are at increased risk for infection.
- Tobacco use interventions for children and adolescents, including education or brief counseling, to prevent initiation of tobacco use.
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children.
- Well-baby and well-child visits.

35. **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.
- Inpatient stay following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and:
  - In accordance with protocols and guidelines based on sound scientific evidence.
  - Upon evaluation of the Insured.
- A post-discharge Physician office visit or in-home nurse visit to verify the Insured's condition in the first 48 hours after discharge.

See also Benefits for Breast Implant Removal.

36. **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 for the treatment of diabetes, 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.
- Cartridges for the legally blind.
- Lancets and lancet devices.
- Glucagon emergency kits.

See also Benefits for A1C Testing.

37. **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.

Benefits also include Private Duty Nursing services provided by a Registered Nurse or licensed practical nurse only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private duty nursing services includes teach and monitoring of complex care skills such as a tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care.

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

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

Hospice care includes:
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.
- Coordinated home care.
- Medical supplies and dressings.
- Medication.
- Nursing services - skilled and non-skilled.
- Occupational therapy.
- Pain management services.
- Physical therapy.
- Physician visits.
- Social and spiritual services.
- Respite care service.

Hospice care does not includes:
- Durable medical equipment.
- Home delivered meals.
- Homemaker services.
- Traditional medical services provided for the direct care of the terminal illness, desease or condition.
- Transportation, including, but not limited to, ambulance transportation.

39. **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.

40. **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.
- Following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

Benefits include room, board, general nursing care, and ancillary services (such as drugs and surgical dressings or supplies).

Benefits do not include admissions to a Skilled Nursing Facility which are for the convenience of the Insured or the Insured's Physician or because care is not available in the Insured's home or the Insured's home is unsuitable for such care.

41. **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.

42. **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.

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

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

44. **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 directly related to organ removal, including preparation and delivery of the donor organ, are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy.

Donor costs are limited to donor:
- Identification.
- Evaluation.
- Organ removal.
- Direct follow-up care.

Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

No benefits are payable for transplants which:
- Are considered an Experimental Treatment (as defined), unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services that such procedure is either experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable.
- Involve permanent mechanical or animal organs.

Benefits will be provided for transportation and lodging for the Insured and a companion. For benefits to be available, the Insured's place of residency must be more than 50 miles from the Hospital where the transplant will be performed. Benefits will be based on reasonable and necessary transportation and lodging expenses using the Company's guidelines.

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

46. **Allergy Testing and Treatment.**
Same as any other Sickness in connection with allergy testing and treatment.

47. **Bariatric Surgery.**
Same as any other Sickness in connection with bariatric surgery for the treatment of morbid obesity.

48. **Continuous Glucose Monitors.**
Benefits are payable as specified in the Schedule of Benefits for a one month supply for Medically Necessary continuous glucose monitors, including one transmitter if necessary for an Insured diagnosed with any form of diabetes mellitus who requires insulin for the management of their diabetes.

Benefits include coverage for continuous glucose monitors, related supplies, and training in the use of the continuous glucose monitor when the following requirements are met:

1. The Insured is diagnosed with diabetes mellitus.
2. The continuous glucose monitor has been prescribed by a Physician licensed under the Medical Practice Act of 1987 or a certified nurse practitioner or physician assistant with a collaborative agreement with the Physician.
3. The continuous glucose monitor has been prescribed in accordance with the Food and Drug Administration's indications for use.

4. The prescriber has concluded that the Insured or Insured's caregiver has sufficient training in using the continuous glucose monitor, which may be evidenced by the prescriber having prescribed a continuous glucose monitor, and has attested that the Insured will be provided with that training.
5. The Insured either:
    - Uses insulin for treatment via one or more injections or infusions of insulin per day, and only one injection or infusion of one type of insulin shall be sufficient utilization of insulin to qualify for a continuous glucose monitor.
    - Has reported a history of problematic hypoglycemia with documentation to the Insured's Physician showing at least one of the following:
    - Recurrent hypoglycemic events characterized by an altered mental or physical state, despite multiple attempts to adjust medications or modify the diabetes treatment plan, as documented by a Physician.
    - A history of at least one hypoglycemic event characterized by an altered mental or physical state requiring third-party assistance for treatment of hypoglycemia, as documented by the Insured's Physician, which may be self-reported by the Insured; third-party assistance shall not, in any event, be deemed to require that the Insured had been admitted to a Hospital or visited an emergency department.

Within six months prior to prescribing a continuous glucose monitor, the Physician prescribing the continuous glucose monitor had an in-person or covered Telehealth visit with the Insured to evaluate the Insured's diabetes control and has determined that the criteria of items (1) through (5) above are met.

To qualify for a continuous glucose monitor, an Insured is not required to:

1. Have a diagnosis of uncontrolled diabetes.
2. Have a history of emergency room visits or hospitalizations.
3. Show improved glycemic control.

All continuous glucose monitors covered under this benefit shall be approved for use by Insureds, and the choice of device shall be made based upon the Insured's circumstances and medical needs in consultation with the Insured's Physician.

49. **Hearing Instruments or Hearing Aids.**
Hearing Instruments or Hearing Aids when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness).

"Hearing instrument or hearing aid" means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including an ear mold but excluding batteries and cords.

Benefits also include related services such as:
- Audiological exams.
- Selection, fitting and adjustment of ear molds to maintain optimal fit.
- Hearing instrument repairs when Medically Necessary.

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

50. **Infertility Treatment.**
Benefits will be paid the same as any other Sickness for Covered Medical Expenses for the diagnosis and treatment of Infertility including, but not limited to, in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, surgical sperm extraction procedures, and low tubal ovum transfer.

Benefits will also be provided for procedures necessary to screen or diagnose a fertilized egg before implantation, including, but not limited to, preimplantation genetic testing for:
- Aneuploidy.
- Chromosome structural rearrangements.
- Monogenic or single gene disorders.

Benefits are provided only if the procedures are:

- Considered medically appropriate by the Insured's Physician based on clinical guidelines or standards developed by the American Society for Reproductive Medicine, the American College of Obstetricians, or the Society for Assisted Reproductive Technology.
- Performed at medical facilities or clinics that are members in good standing of the Society for Assisted Reproductive Technology.

"Infertility" means a disease, condition, or status characterized by:
- A failure to establish a pregnancy or to carry a pregnancy to live birth after 12 months of regular, unprotected sexual intercourse if the woman is 35 years of age or younger, or after 6 months of regular, unprotected sexual intercourse if the woman is over 35 years of age; conceiving but having a miscarriage does not restart the 12-month or 6-month term for determining infertility.
- An Insured's ability to reproduce either as a single individual or with a partner without medical intervention.
- A licensed Physician's findings based on an Insured's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing.

The one year requirement will be waived if the Insured's Physician determines that:
- A medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to chemotherapy or radiation treatments.
- Efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Benefits for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer will be provided only when:
- The Insured has been unable to attain a viable pregnancy, maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly, medically appropriate infertility treatments that are Covered Medical Expenses.
- The Insured has not undergone four completed oocyte retrievals, except that if a live birth followed a completed oocyte retrieval, two more completed oocyte retrievals after the first live birth shall be covered.
- The procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Benefits will also be provided for a donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to the Insured or to the surrogate. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

The maximum number of completed oocyte retrievals eligible for coverage is six. Following the final completed oocyte retrieval, benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Insured. Thereafter, the Insured will have no benefits for infertility treatment, except for the transfer of retrieved oocytes or resulting embryos to the Insured or a surrogate and other Medically Necessary fertility services until the Insured or surrogate is discharge to regular obstetrical care.

Benefits for Infertility treatment do not include:
- Services or supplies rendered to a surrogate after the surrogate has been discharged to regular obstetrical care, non-Medical expenses incurred by the Insured to the contract with the surrogate, and any other services rendered to a surrogate that are not directly related to treatment of the Insured's Infertility.
- Cryo-preservation or storage of sperm, eggs or embryos, except for procedures that use a cryo-preserved substance.
- Non-medical expenses of a donor or surrogate.
- Travel expenses for travel within 100 miles of the Insured's home or travel expense that are not Medically Necessary.
- Infertility treatments that are deemed experimental or investigational according to the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.

51. **Medical Foods.**
Benefits are limited to amino acid-based elemental formulas provided for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome. Medical foods must be prescribed by a Physician. The written prescription must accompany the claim when submitted.

52. **Oral Surgery.**
Benefits will be paid the same as any other Sickness for the following:
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Surgical procedures to correct accidental Injury of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses).
- Treatment of fractures of facial bone.
- External incision and drainage of cellulitis
- Incision of accessory sinuses, salivary glands or ducts.
- Reduction of dislocation of, or excision of, the temporomandibular joints.

53. **Surgically Implanted Hearing Devices.**
Benefits will be paid the same as any other Sickness for surgically implanted hearing devices

Benefits are limited to the following hearing devices for hearing loss severe enough that it would not be remedied by a wearable hearing aid:
- Cochlear devices.
- Bone anchored hearing aids for an Insured with craniofacial anomalies whose abnormal or absent ear canals prevent the use of a wearable hearing aid.

Benefits include any Medically Necessary services related to the implantation of the device.

54. **Temporomandibular Joint Disorder.**
Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.
"Temporomandibular joint dysfunction and related disorders" means jaw joint conditions, including:
- Temporomandibular joint disorders.
- Craniomandibular disorders.
- All other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues relating to that joint.

See also Benefits for Jaw Care Services

Section 7: Mandated Benefits

EXAMINATION AND TREATMENT FOR SEXUAL ASSAULT

Benefits will be provided for exam and testing of a victim of a criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection. Benefits also include exam and treatment of Injuries and trauma sustained by the victim.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL CARE

Benefits will be paid the same as any other Sickness for anesthesia and associated Hospital or ambulatory facility charges provided in conjunction with dental care for:

1. An Insured child age six and under.
2. An Insured who is disabled.
3. An Insured with a medical condition requiring hospitalization or general anesthesia for dental care.

Benefits will be paid the same as any other Sickness for general anesthesia provided by a dentist or an oral surgeon who has obtained a permit for administration of anesthetics under the Illinois Dental Practice Act, in conjunction with dental care that is provided to an Insured in a dental office, oral surgeon's office, Hospital or ambulatory surgical treatment center if the Insured Person:

1. Is under age 26; and
2. Has been diagnosed with an autism spectrum disorder or a developmental disability.
3. Has made two visits to the dental care provider before administration of the anesthesia.

This benefit does not cover charges for the dental care itself, only charges for the anesthesia and associated Hospital or ambulatory facility charges.

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

BENEFITS FOR MAMMOGRAPHY

Benefits will be provided for screening by Low-dose Mammography for the presence of occult breast cancer according to the following guidelines:

1. A baseline mammogram for an Insured 35 to 39 years of age.
2. An annual mammogram for an Insured 40 years of age or older.
3. A mammogram at the age and intervals considered Medically Necessary by the Insured's Physician for an Insured under 40 years of age and having a family history of breast cancer, prior personal history of breast cancer, positive genetic testing, or other risk factors.
4. A comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue or when Medically Necessary as determined by a Physician.
5. A screening MRI when Medically Necessary, as determined by a Physician.
6. A Diagnostic Mammogram when Medically Necessary, as determined by a Physician.

"Diagnostic mammogram" means a mammogram obtained using diagnostic mammography.

"Diagnostic mammography" means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

"Low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average size breast.

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

BENEFITS FOR MEDICATION AND THERAPY FOR BREAST CANCER PAIN

Benefits will be paid the same as any other Sickness for all Medically Necessary pain medication and Pain Therapy related to the treatment of breast cancer.

"Pain therapy" means pain therapy that is medically based and includes reasonable defined goals, including, but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

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

BENEFITS FOR BREAST IMPLANT REMOVAL

Benefits will be paid the same as any other Sickness for the removal of breast implants when the removal of the implants is Medically Necessary treatment for a Sickness or Injury. No benefits will be provided for surgery to remove breast implants that were implanted solely for cosmetic reasons.

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

BENEFITS FOR PANDAS AND PANS TREATMENT

Benefits will be paid the same as any other Sickness for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS), including, but not limited to, the use of intravenous immunoglobulin therapy.

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

BENEFITS FOR MULTIPLE SCLEROSIS PREVENTIVE PHYSICAL THERAPY

Benefits will be provided for Medically Necessary Preventive Physical Therapy for Insureds diagnosed with multiple sclerosis. Benefits will be paid the same as physical therapy provided for any other Sickness.

"Preventive physical therapy" means physical therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals.

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

BENEFITS FOR CLINICAL BREAST EXAMS

Benefits will be provided for complete and thorough clinical breast examinations as indicated by guidelines of practice, performed by a Physician, a licensed advanced practice registered nurse, or a licensed physician assistant, to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

1. At least every three years for women at least 20 years of age but less than 40 years of age; and
2. Annually for women 40 years of age or older.

Benefits are also available for an Insured who has been diagnosed with a fibrocystic breast condition.

When the clinical breast exam is performed in accordance with Preventive Care Services and are provided by a Preferred Provider, benefits shall not be subject to any Deductible, Copayment, or Coinsurance but shall be subject to all other limitations and provisions of the Policy.

When services are provided by an Out-of-Network Provider 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 following contraceptive services and contraceptive methods:

1. All contraceptive drugs, devices, and other products approved by the United States Food and Drug Administration. This includes all over-the-counter contraceptive drugs, devices, and products approved by the United States Food and Drug Administration, excluding, male condoms unless a female Insured obtains the male condom with a prescription.Over-the-counter contraceptive drugs, devices, and products do not require a written prescription. Benefits will be provided for up to a 12 month supply when dispensed at one time.
2. Voluntary sterilization procedures.
3. Contraceptive services, patient education, and counseling on contraception.
4. Follow-up services related to the drugs, devices, products, and procedures covered under this section, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

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

BENEFITS FOR CERVICAL, OVARIAN, PROSTATE CANCER TESTING, AND GENETIC TESTING

Benefits will be provided for:

1. Pap tests.
2. Prostate-specific antigen tests.
3. Genetic testing of the BRCA1 and BRCA2 genes to detect an increased risk for breast and/or ovarian cancer in accordance with the USPSTF.

Benefits include all of the following:

1. An annual cervical smear or Pap smear test for all Insureds.
2. An annual Prostate Cancer Screening, for male Insureds upon the recommendation of a Physician for:
   a. Asymptomatic Insured's age 50 and over;
   b. African-American Insured's age 40 and over; and
   c. Insured's age 40 and over with a family history of or genetic predisposition to prostate cancer.

3. Surveillance tests for ovarian cancer for female Insureds who are At Risk for Ovarian Cancer.

“At risk for ovarian cancer” means any one of the following:

1. Having a family history:
   a. With one or more first-degree relatives with ovarian cancer.
   b. Of clusters of women relatives with breast cancer.
   c. Of nonpolyposis colorectal cancer.
2. Testing positive for BRCA1 or BRCA2 mutations.

"Prostate cancer screening" means medically viable methods for the detection and diagnosis of prostate cancer, including a digital rectal exam and the prostate-specific antigen test and associated laboratory work upon the recommendation of a Physician for any of the following:

1. Urinary analysis.
2. Serum biomarkers.
3. Medical imaging, including, but not limited to, magnetic resonance imaging.

“Surveillance tests for ovarian cancer” means annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

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

BENEFITS FOR IMMUNOSUPPRESSANT DRUGS

Benefits will be paid the same as any other Prescription Drug for immunosuppressant drug prescriptions.

When the prescribing Physician has indicated on a prescription “may not substitute,” the Company will not require or cause a pharmacist to interchange another immunosuppressant drug or formulation unless the Company receives notification and documented consent. Consent is required from the prescribing Physician and the Insured patient, or the parent or guardian if the patient is a child, or the spouse of a patient who is authorized to consent to the treatment of the person.

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

BENEFITS FOR IMMUNE GAMMA GLOBULIN THERAPY

Benefits will be paid the same as any other Sickness for immune gamma globulin therapy when prescribed as Medically Necessary by a Physician for Insureds who are diagnosed with a primary immunodeficiency.

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

BENEFITS FOR TREATMENT MODELS FOR EARLY TREATMENT OF SERIOUS MENTAL ILLNESS

Benefits will be paid the same as any other Mental Illness for the below specified treatment models for early treatment of serious Mental Illnesses in children or young adults under age 26.

Benefits will be provided for the following bundled, evidence-based treatment:

1. Coordinated specialty care for first episode psychosis treatment, covering the elements of the treatment model included in the most recent national research trials conducted by the National Institute of Mental Health in the Recovery After an Initial Schizophrenia Episode (RAISE) trials for psychosis resulting from a serious Mental Illness, but excluding components of the treatment model related to education and employment.
2. Assertive community treatment (ACT) and community support team (CST) treatment.

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

BENEFITS FOR LONG-TERM ANTIBIOTIC THERAPY FOR TICK-BORNE DISEASES

Benefits will be paid the same as any other Sickness for Long-Term Antibiotic Therapy for Tick-Borne Diseases.

Benefits include Physician’s Visits and ongoing testing for an Insured with a Tick-Borne Disease when determined to be Medically Necessary and ordered by a Physician after making a thorough evaluation of the Insured’s symptoms, diagnostic test results, or response to treatment. An experimental drug shall be covered as a Long-Term Antibiotic Therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall

be covered for an off-label use in the treatment of a Tick-Borne Disease if the drug has been approved by the United States Food and Drug Administration.

"Long-term antibiotic therapy" means the administration of oral, intramuscular, or intravenous antibiotics singly or in combination for periods of time in excess of four weeks.

"Tick-borne disease" means a disease caused when an infected tick bites an Insured and the tick's saliva transmits an infectious agent (bacteria, viruses, or parasites) that can cause Sickness, including, but not limited to, the following:

1. A severe infection with borrelia burgdorferi.
2. A late stage, persistent, or chronic infection or complications related to such an infection.
3. An infection with other strains of borrelia or a tick-borne disease that is recognized by the United States Centers for Disease Control and Prevention.
4. The presence of signs or symptoms compatible with acute infection of borrelia or other tick-borne diseases.

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

BENEFITS FOR HUMAN BREAST MILK

Benefits will be paid the same as any other Sickness for pasteurized donated human breast milk which may include human milk fortifiers if indicated by a Physician.
Benefits are subject to the following conditions:

1. The Insured is an infant under the age of 6 months and all of the following conditions are met:
   a. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
   b. The infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated.
   c. The milk has been determined Medically Necessary for the infant.
   d. One or more of the following applies:
      - The infant's birth weight is below 1,500 grams.
      - The infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
      - The infant has infant hypoglycemia.
      - The infant has congenital heart disease.
      - The infant has had or will have an organ transplant.
      - The infant has sepsis.
      - The infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant.
2. The Insured is a child 6 months through 12 months of age and all of the following conditions are met:
   a. The milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health.
   b. The child's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the child's needs or the maternal breast milk is contraindicated.
   c. The milk has been determined to be Medically Necessary for the child.
   d. One or more of the following applies:
      - The child has spinal muscular atrophy.
      - The child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity.
      - The child has had or will have an organ transplant.
      - The child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

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

BENEFITS FOR WHOLE BODY SKIN EXAMINATIONS

Benefits will be provided for one office visit per Policy Year for a whole body examination for lesions suspicious for skin cancer.

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

BENEFITS FOR PANCREATIC CANCER SCREENING

Benefits will be paid the same as any other Sickness for Medically Necessary pancreatic cancer screening.

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

BENEFITS FOR BIOMARKER TESTING

Benefits will be paid the same as any other Sickness for Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an Insured's disease or condition when the test is supported by medical and scientific evidence.

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Biomarker includes, but is not limited to, gene mutations or protein expression.

"Biomarker testing" means the analysis of a patient's tissue, blood, or fluid biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

Biomarker Testing shall be covered and conducted in an efficient manner to provide the most complete range of results to the Insured's Physician without requiring multiple biopsies, biospecimen samples, or other delays or disruptions in the Insured's care.

Biomarker Testing will be covered when the test is supported by medical and scientific evidence, including, but not limited to:

1. Labeled indications for an FDA-approved test or indicated tests for an FDA-approved drug.
2. Federal Centers for Medicare and Medicaid Services National Coverage Determinations.
3. Nationally recognized clinical practice guidelines.
4. Consensus statements.
5. Professional society recommendations.
6. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database of Health Services Technology Assessment Research.
7. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

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

BENEFITS FOR A1C TESTING

Benefits will be paid the same as any other Sickness for A1C Testing recommended by a health care provider for prediabetes, type 1 diabetes, and type 2 diabetes in accordance with prediabetes and diabetes risk factors identified by the United States Centers for Disease Control and Prevention.

Risk factors for prediabetes may include, but are not limited to, being overweight or obese, being aged 35 or older, having an immediate family member with type 2 diabetes, previous diagnosis of gestational diabetes and being African American, Hispanic or Latino American, American Indian, or Alaska Native. Risk factors for type 1 diabetes may include, but are not limited to, family history of diabetes. Risk factors for type 2 diabetes may include, but are not limited to, having prediabetes, being overweight or obese, being aged 35 or older, having an immediate family member with type 1 or type 2 diabetes, previous diagnosis of gestational diabetes and being African American, Hispanic or Latino American, American Indian, or Alaska Native.

"A1C testing" means blood sugar level testing used to diagnose prediabetes, type 1 diabetes, and type 2 diabetes and to monitor management of blood sugar levels.

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

BENEFITS FOR VITAMIN D TESTING

Benefits will be paid the same as any other Sickness for Vitamin D Testing recommended by a health care provider in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention.

Risk factors for vitamin D deficiency include, but are not limited to:

1. Having osteoporosis or other bone-health problems.
2. Having conditions that affect fat absorption, including celiac disease or weight loss surgery.
3. Routinely taking medications that interfere with vitamin D activity, including anticonvulsants and glucocorticoids.
4. Insureds aged 55 and older.
5. Having a darker skin color.
6. Inadequate sunlight exposure.
7. Being obese.
8. Previous diagnosis of diabetes or kidney disease.
9. Exhibiting poor muscle strength or constant tiredness.

“Vitamin D testing” means vitamin D blood testing that measures the level of vitamin D in an individual’s blood.

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

BENEFITS FOR COMPREHENSIVE CANCER TESTING AND TESTING OF BLOOD OR CONSTITUTIONAL TISSUE FOR CANCER PREDISPOSTION TESTING

Benefits will be paid the same as any other Sickness for Medically Necessary Comprehensive Cancer Testing and Testing of Blood or Constitutional Tissue for Cancer Predisposition as determined by a Physician licensed to practice medicine in all of its branches.

Comprehensive cancer testing includes, but is not limited to, the following forms of testing:

1. Targeted cancer gene panels.
2. Whole-exome genome testing.
3. Whole-genome sequencing.
4. RNA sequencing.
5. Tumor mutation burden.

Testing of blood or constitutional tissue for cancer predisposition includes, but is not limited to, the following forms of testing:

1. Targeted cancer gene panels.
2. Whole-exome genome testing.
3. Whole-genome sequencing.

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

BENEFITS FOR PORT-WINE STAIN TREATMENT

Benefits will be paid the same as any other Sickness for treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including, but not limited to, port-wine stains caused by Sturge-Weber syndrome.

Treatment or maximum feasible treatment shall include early intervention treatment, including topical, intralesional, or systemic medical therapy and surgery, and laser treatments approved by the U.S. Food and Drug Administration in children aged 18 years and younger that are intended to prevent functional impairment related to vision function, oral function, inflammation, bleeding, infection, and other medical complications associated with port-wine stains.

Coverage shall not include treatment solely for cosmetic purposes.

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

BENEFITS FOR STANDARD FERTILITY PRESERVATION SERVICES RELATED TO IATROGENIC INFERTILITY TREATMENT

Benefits will be paid the same as any other Sickness for Medically Necessary expenses for Standard Fertility Preservation Services when a necessary medical treatment may directly or indirectly cause Iatrogenic Infertility to an Insured Person.

"Iatrogenic infertility" means an impairment of fertility by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

"May directly or indirectly cause" means the likely possibility that treatment will cause a side effect of infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

"Standard fertility preservation services" means procedures based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

Coverage will not be denied based on an Insured Person's expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other medical conditions, nor based on personal characteristics, including age, sex, sexual orientation, or marital status.

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

BENEFITS FOR BREAST REDUCTION SURGERY

Benefits will be paid the same as any other Sickness for breast reduction surgery when the reduction is a Medically Necessary treatment for a Sickness or Injury.
Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CLEFT LIP AND CLEFT PALATE

Benefits will be paid the same as any other Sickness for Medically Necessary Care and Treatment for cleft lip and cleft palate for Insureds under age 19.

"Medically Necessary care and treatment" includes:

1. Oral and facial surgery, including reconstructive services and procedures necessary to improve and restore and maintain vital functions.
2. Prosthetic treatment such as obdurators, speech appliances, and feeding appliances.
3. Orthodontic treatment and management.
4. Prosthodontic treatment and management.
5. Otolaryngology treatment and management.

Medically Necessary Care and Treatment does not include cosmetic surgery performed to reshape normal structures of the lip, jaw, palate, or other facial structures to improve appearance.

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

BENEFITS FOR PEDIATRIC PALLIATIVE CARE

Benefits will be paid the same as any other Sickness for pediatric palliative care for any qualified Insured child with a serious Sickness.

Benefits include care provided by a trained interdisciplinary team that allows an Insured child to receive community-based pediatric palliative care while continuing to pursue curative treatment and disease-directed therapies for the qualifying Sickness.

Covered Medical Expenses for hospice care provided by a licensed hospice agency are described under Hospice Care.

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

BENEFITS FOR HORMONAL AND NON-HORMONAL THERAPY TREATMENT

Benefits will be paid the same as any other Sickness for Medically Necessary hormonal and non-hormonal therapy treatment to treat menopausal symptoms induced by a hysterectomy if the therapy is recommended by a qualified Physician and the therapy has been proven safe and effective in peer-reviewed scientific studies.

Benefits for therapy to treat menopausal symptoms shall include all federal Food and Drug Administration-approved modalities of hormonal and non-hormonal administration, including but not limited to:

1. Oral.
2. Transdermal.
3. Topical.
4. Vaginal rings.

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

BENEFITS FOR PRENATAL VITAMINS

Benefits will be paid the same as any other Sickness for prenatal vitamins when prescribed by a Physician or advanced practice registered nurse.

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

BENEFITS FOR OPIOID ANTAGONISTS

Benefits will be paid for Opioid Antagonists.

Covered Medical Expenses include:
1. The medication product.
2. Administration devices.
3. Any pharmacy administration fees related to dispensing of the Opioid Antagonist.

Benefits include refills for expired or utilized Opioid Antagonists.

"Opioid antagonist" means a drug that binds to opioid receptors and blocks or inhibits the effect of opioids acting on those receptors, including, but not limited to, naloxone hydrochloride or any other similarly acting drug approved by the U.S. Food and Drug Administration.

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

BENEFITS FOR ABORTIFACIENTS AND HORMONAL THERAPY MEDICATION, PRE-EXPOSURE AND POST-EXPOSURE PROPHYLAXIS

Benefits will be paid for abortifacients, hormonal therapy medication for the treatment of gender dysphoria, and human immunodeficiency virus pre-exposure prophylaxis and post-exposure prophylaxis, including off-label use.

Benefits include human immunodeficiency virus pre-exposure prohhylaxis and post-exposure prophylaxis drugs approved by the United States Food and Drug Administation (FDA), and follow-up services related to that coverage, including but not limited to:
1. Management of side effects.
2. Medication self-management or adherence counseling.
3. Risk reduction strategies.
4. Mental health counseling.

Benefits are provided when the following conditions are met:
1. If the FDA has approved one or more therapeutic equivalent versions of an Abortifacient drug, at least one will be covered without cost share in accordance with state law.
2. If an Insured Person's attending Physician recommends a particular drug approved by the FDA based on a determination of Medical Necessity.
3. If a drug is not covered, an exception review process is available to allow a pathway to coverage without cost share.

Benefits also include drugs approved by the FDA that are prescribed or ordered for off-label use for the purposes described in the mandated benefit.

"Abortifacients" means any medication administered to terminate a pregnancy as prescribed or ordered by a health care professional.

The Company shall not impose restrictions or delays for the coverage provided under this mandate.

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

BENEFITS FOR CUSTOMIZED ORTHOTIC DEVICES

Benefits will be paid for Customized Orthotic Devices recommended by a Physician to be the most appropriate model for the Insured Person to perform physical activities as applicable such as running, biking, swimming, and lifting weights, and to maximize the Insured Person's health and strengthen the lower and upper limb function.

"Customized orthotic device" means a supportive device for the body or a part of the body, the head, neck, or extremities and includes the replacement or repair of the device based on the Insured's physical condition as Medically Necessary. Foot orthotics defined as an in-shoe device designed to support the structural components of the foot during weight-bearing activities are excluded from this definition.

Repairs and replacements of prosthetic and orthotic devices are also covered, unless necessitated by misuse or loss.

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

BENEFITS FOR PREVENTIVE LIVER DISEASE SCREENINGS

Benefits will be paid for preventive liver disease screenings for Insureds age 35 to 65 at high risk for liver disease, including liver ultrasounds and alpha-fetoprotein blood tests every six months.

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

BENEFITS FOR COMPRESSION SLEEVES

Benefits will be paid the same as any other Sickness for Medically Necessary compression sleeves for an Insured to prevent or mitigate lymphedema.

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

BENEFITS FOR RECONSTRUCTIVE SERVICES

Benefits will be paid the same as any other Sickness for Medically Necessary Reconstructive Services that are intended to restore physical appearance.

"Reconstructive services" means treatments performed on structures of the body damaged by trauma to restore physical appearance.

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

BENEFITS FOR PROTON BEAM THERAPY

Benefits will be paid the same as any other Sickness for Medically Necessary Proton Beam Therapy for the treatment of cancer.

"Proton beam therapy" means a type of Radiation Therapy Treatment that utilizes protons as the radiation delivery method for the treatment of tumors and cancerous cells.

"Radiation therapy treatment" means the delivery of biological effective doses with proton therapy, intensity modulated radiation therapy, brachytherapy, stereotactic body radiation therapy, three-dimensional conformal radiation therapy, or other forms of therapy using radiation.

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

BENEFITS FOR HOME SALIVA CANCER SCREENING

Benefits will be paid the same as any other Sickness for Medically Necessary Home Saliva Cancer Screening every 24 months if the Insured:

1. Is asymptomatic and at high risk for the disease being tested for.

2. Demonstrates symptoms of the disease being tested for at a physical exam.

"Home saliva cancer screening" means an outpatient test that utilizes an Insured's saliva to detect biomarkers for early-stage cancer.

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

BENEFITS FOR CHILDREN WITH NEUROMUSCULAR, NEUROLOGICAL, OR COGNITIVE IMPAIRMENT

Benefits will be paid the same as any other Sickness for therapy, diagnostic testing, and equipment necessary to increase quality of life for Dependent children who have been clinically or genetically diagnosed disease, syndrome, or disorder that includes low tone neuromuscular impairment, neurological impairment, or cognitive impairment.

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

BENEFITS FOR MENTAL HEALTH AND WELLNESS VISITS

Benefits will be paid for any age-appropriate mental health screening for the purpose of:

1. Identifying a mental health issue, condition, or disorder.
2. Discussing mentally health symptoms that might be present, including symptoms of a previously diagnosed mental health condition or disorder.
3. Performing an evaluation of adverse childhood experiences.
4. Discussing mental health and wellness.

Screening shall be provided in accordance with recommendations by the United States Preventive Services Task Force or by the American Academy of Pediatrics' Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.

A mental health and wellness visit shall be performed by a Physician licensed to practice medicine in all of its branches, a licensed clinical psychologist, a licensed social worker, a licensed clinical professional counselor, a licensed marriage and family therapist, a licensed social worker, or a licensed professional counselor for up to a 60 minute visit limited to one visit per Policy Year.

The visit shall be in addition to any annual physical examination and shall not replace a well-child visit or a general health or medical visit.

A mental health and wellness visit shall be reimbursed through the following American Medical Association current procedural terminology codes: 99381-99387 and 99391-99397.

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

BENEFITS PROVIDED BY A PHARMACIST

Benefits are provided the same as any other Sickness for the following services when performed by a pharmacist in accordance with the Pharmacy Practice Act:

1. Vaccinations of Insureds age 7 and older for COVID-19 or influenza. Vaccine may be provided subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the United States Food and Drug Administration (USFDA).
2. Administration of COVID-19 therapeutics subcutaneously, intramuscularly, or orally with notification to the Insured's Physician. Eligible therapeutics are those approved, authorized, or licensed by the USFDA and must be administered subcutaneously, intramuscularly, or orally in accordance with the approval, authorization, or licensing.
3. Administration of the following tests and screenings, with notification to the Insured's Physician, for:
   - Influenza.
   - SARS-COV 2.
   - Health conditions identified by a statewide public health emergency, as defined in the Illinois Emergency Management Agency Act.

   Eligible tests and screenings are those approved, authorized, or licensed by the USFDA and must be administered in accordance with the approval, authorization, or licensing.

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

BENEFITS FOR BONE MASS MEASUREMENT AND OSTEOPOROSIS

Benefits will be provided for Medically Necessary bone mass measurement and for the diagnosis and treatment of osteoporosis.

When the bone mass measurement and/or diagnosis and treatment of osteoporosis is performed in accordance with Preventive Care Services and are provided by a Preferred Provider, benefits shall not be subject to any Deductible, Copayment, or Coinsurance but shall be subject to all other limitations and provisions of the Policy.

When services are provided by an Out-of-Network Provider benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CONTINUOUS GLUCOSE MONITORS

Benefits are provided for a one month supply for Medically Necessary continuous glucose monitors, including one transmitter if necessary for an Insured diagnosed with any form of diabetes mellitus who requires insulin for the management of their diabetes.

Benefits include coverage for continuous glucose monitors, related supplies, and training in the use of the continuous glucose monitor when the following requirements are met:

1. The Insured is diagnosed with diabetes mellitus.
2. The continuous glucose monitor has been prescribed by a Physician licensed under the Medical Practice Act of 1987 or a certified nurse practitioner or physician assistant with a collaborative agreement with the Physician.
3. The continuous glucose monitor has been prescribed in accordance with the Food and Drug Administration's indications for use.
4. The prescriber has concluded that the Insured or Insured’s caregiver has sufficient training in using the continuous glucose monitor, which may be evidenced by the prescriber having prescribed a continuous glucose monitor, and has attested that the Insured will be provided with that training.
5. The Insured either:
    - Uses insulin for treatment via one or more injections or infusions of insulin per day, and only one injection or infusion of one type of insulin shall be sufficient utilization of insulin to qualify for a continuous glucose monitor.
    - Has reported a history of problematic hypoglycemia with documentation to the Insured's Physician showing at least one of the following:
        - Recurrent hypoglycemic events characterized by an altered mental or physical state, despite multiple attempts to adjust medications or modify the diabetes treatment plan, as documented by a Physician.
        - A history of at least one hypoglycemic event characterized by an altered mental or physical state requiring third-party assistance for treatment of hypoglycemia, as documented by the Insured’s Physician, which may be self-reported by the Insured; third-party assistance shall not, in any event, be deemed to require that the Insured had been admitted to a Hospital or visited an emergency department.

Within six months prior to prescribing a continuous glucose monitor, the Physician prescribing the continuous glucose monitor had an in-person or covered Telehealth visit with the Insured to evaluate the Insured’s diabetes control and has determined that the criteria of items (1) through (5) above are met.

To qualify for a continuous glucose monitor, an Insured is not required to:

1. Have a diagnosis of uncontrolled diabetes.
2. Have a history of emergency room visits or hospitalizations.
3. Show improved glycemic control.

All continuous glucose monitors covered under this benefit shall be approved for use by Insureds, and the choice of device shall be made based upon the Insured's circumstances and medical needs in consultation with the Insured's Physician.

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

BENEFITS FOR WIGS OR OTHER SCALP HAIR PROSTHESIS

Benefits are provided for one wig or other scalp hair prothesis, every 12 months, worn for hair loss caused by alopecia, chemotherapy, or radiation treatment for cancer or other conditions.

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

BENEFITS FOR COLONOSCOPY

Benefits will be paid the same as any other Sickness for a Medically Necessary colonoscopy.

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

BENEFITS FOR VACCINATIONS AND ADMINISTRATION FEES

Benefits are provided for vaccinations administered by a pharmacist or Physician authorized to administer such a vaccine and ordered and administered according to the State Guidelines for Communicable Disease Prevention.

Benefits are provided for the following vaccines, including administrative fees:
1. COVID-19 vaccine.
2. Influenza vaccine.
3. Respiratory syncytial virus vaccine.

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

BENEFITS FOR JAW CARE SERVICES

Benefits will be paid the same as any other Injury or Sickness for Medically Necessary care and treatment to address a major injury to the jaw as a result or Injury or Sickness.

Benefits include:
1. Oral and facial surgery, including reconstructive services and procedures necessary to improve, restore, or maintain vital functions.
2. Dental implants, crowns, or bridges.
3. Prosthetic treatment such as obturators, speech appliances, and feeding appliances.
4. Orthodontic treatment and management.
5. Prosthodontic treatment and management.
6. Otolaryngology treatment and management.

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

BENEFITS FOR MOBILE INTERGATED HEALTH CARE SERVICES

Benefits will be paid the same as any other Sickness for Medically Necessary Mobile Integrated Health Care Services provided to an Eligible Recipient.

"Eligible recipient" means an Insured who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an Insured Person who has been identified by a Physician as an individual for whom Mobile Integrated Health Care Services would likely prevent admission or readmission to or would allow discharge from a Hospital, behavioral health facility, acute care facility, or nursing facility.

"Mobile integrated health care services" means Medically Necessary health services provided on-site by emergency medical services personnel, as defined in Section 5 of the Emergency Medical Services (EMS) Systems Act.

Mobile Integrated Health Care Services includes:
1. Health assessment.
2. Chronic disease monitoring and education.
3. Medication compliance.

4. Immunizations and vaccinations.
5. Laboratory specimen collection.
6. Hospital discharge follow-up care.
7. Minor medical procedures as approved by the applicable EMS Medical Director.

Mobile Integrated Health Care Services does not include nonemergency ambulance transport.

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

BENEFITS FOR ANNUAL MENOPAUSE HEALTH VISIT

Benefits will be paid for an annual menopause health visit for Insureds age 45 and older.

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

BENEFITS FOR AUTISM SPECTRUM DISORDER

Benefits will be paid as any other Sickness for Medically Necessary Diagnosis of Autism Spectrum Disorders and the treatment of Autism Spectrum Disorders.

Treatment for autism spectrum disorders shall include the following care prescribed, provided, or ordered for an Insured diagnosed with an Autism Spectrum Disorder by:

1. A Physician licensed to practice medicine in all its branches.
2. A certified, registered, or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches:

Benefits include:

1. Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
2. Psychological care, meaning direct or consultative services provided by a licensed psychologist.
3. Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are intended to develop, maintain, and restore the functioning of an Insured.
4. Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
    a. Self care and feeding.
    b. Pragmatic, receptive, and expressive language.
    c. Cognitive functioning.
    d. Applied Behavior Analysis, intervention, and modification.
    e. Motor planning.
    f. Sensory processing.

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an Insured has Autism Spectrum Disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

For the purpose of this benefit, "medically necessary" means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease or disability; (ii) reduce or ameliorate the physical, mental or developmental effects of an Sickness, condition, Injury, disease or disability; or (iii) assist to achieve or maintain maximum functional activity in performing daily activities.

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

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

BENEFITS FOR ABORTION CARE SERVICES

Benefits will be paid for abortion care services without the imposition of any waiting periods, restrictions, or delays for coverage.

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

BENEFITS FOR GENETIC TESTING AND EVIDENCE-BASED SCREENING FOR INHERITED GENE MUTATION

Benefits will be paid the same as any other Sickness for clinical Genetic Testing for an Inherited Gene Mutation for an Insured with a personal or family history of cancer, as recommended by a Physician in accordance with current evidence-based clinical practice guidelines, including, but not limited to, the current version of the National Comprehensive Cancer Network clinical practice guidelines.

Benefits include testing for an Insured with a personal or family history of cancer, not to exceed $50.

For an Insured with a genetic test that is positive for an inherited mutation associated with an increased risk of cancer, benefits also include any Evidence-based Cancer Screenings, as recommended by a Physician in accordance with current evidence-based clinical practice guidelines.

“Evidence-based cancer screenings” means medically recommended evidence-based screening modalities in accordance with current clinical practice guidelines.

"Genetic testing for an inherited mutation" means germline multi-gene testing for an inherited mutation associated with an increased risk of cancer in accordance with evidence-based, clinical practice guidelines.

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:
   - Individual and group insurance contracts and subscriber contracts.
   - Uninsured arrangements of individual, group or group-type coverage.
   - Individual and 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.
   - Disability income protection coverage.

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. There may be more than one primary plan. 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. **Young Adult/Dependent**. If a Dependent child has coverage under either or both parent's Plans and also has his or her own coverage as a Dependent under a spouse's Plan, the rules specified in Section (8) Longer/Shorter Length of Coverage apply. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parent's Plans, the order of benefits shall be determined by applying the birthday rules specified in Section (2), Dependent Child/Parents Married or Living Together, to the Dependent child's parent or parents and the Dependent's spouse.

6. **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.

7. **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.

8. **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.
6. Provided by an Out-of-Network Provider when no other Preferred Provider will provide a service because the Preferred Provider has asserted their rights under the Health Care Right of Conscience Act.

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 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 research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EXPERIMENTAL TREATMENT means medical technology or a new application of existing medical technology, including medical procedures, drugs, and devices for treating a medical condition, illness, or diagnosis that: 1) is not generally accepted by informed health care professionals in the United States as effective; or 2) has not been proven by scientific testing or evidence to be effective.

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, educational/vocational training and residential treatment are not habilitative services.

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

HOSPITAL means a licensed or properly accredited general hospital which is all of the following:

1. Open at all times.
2. Operated primarily and continuously for the treatment of and surgery for sick or injured persons as inpatients.
3. Under the supervision of a staff of one or more legally qualified Physicians available at all times.
4. Continuously provides on the premises 24 hour nursing service by Registered Nurses.
5. Provides organized facilities for diagnosis and major surgery on the premises or in facilities available to the Hospital on a pre-arranged basis.
6. Not primarily a clinic, nursing, rest or convalescent home.

The requirement for major surgery facilities does not apply to treatment or services for rehabilitation or mental illness rendered in a hospital.

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. The direct cause of loss, independent of disease cause of loss, independent of disease or bodily infirmity.
2. A source of loss.
3. Treated by a Physician within 30 days after the date of accident.
4. 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. 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/EMERGENCY MEDICAL CONDITION 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, regardless of the final diagnosis given 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. Inadequately controlled pain.
5. In the case of a pregnant woman, serious jeopardy to the health of the woman or unborn child.
6. With respect to a pregnant woman who is having contractions: (a) inadequate time to complete a safe transfer to another Hospital before delivery; or (b) a transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Expenses incurred for Medical Emergency/Emergency Medical Condition 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 listed in the mental health or psychiatric diagnostic categories, including autism spectrum disorder, in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered from the moment of birth under the Policy for the first 31 days. 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, including a pharmacist, 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.

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

TELEHEALTH/TELEMEDICINE means the evaluation, diagnosis, or interpretation of electronically transmitted patient-specific data between a remote location and a licensed health care professional that generates interaction or treatment recommendations. Telehealth/telemedicine also includes the delivery of health care services, including mental health treatment and substance use disorder treatment and services to a patient, regardless of patient location, provided by way of an interactive telecommunications system providing 2-way, synchronous interactive communication.

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, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acupuncture.
2. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
3. Alternative treatments, such as:
   - Hypnosis.
4. Biofeedback.
5. Cosmetic procedures, except as specifically provided in the Policy or reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions.
6. 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 use facilities for domiciliary or Custodial Care.
7. Dental treatment, except:
   - As described under Dental Treatment in the Policy.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Foot care for the following:
   - 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.
10. Health spa or similar facilities. Strengthening programs.
11. Hearing examinations. Hearing aids, except as specifically provided for in the Policy. 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.
    - Benefits specifically provided in the Policy.
12. Hirsutism. Alopecia.
13. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
14. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
15. Injury sustained while:
    - Participating in any intercollegiate or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
16. Investigational services.

    This exclusion does not apply to benefits specifically provided for an Approved Clinical Trial.
17. Lipectomy.
18. Participation in a riot or civil disorder. Any loss to which a contributing cause was the Insured's commission of or attempt to commit a felony or to which a contributing cause was the Insured being engaged in an illegal occupation.
19. Personal care, comfort, or convenience items not directly related to the treatment of a Sickness or Injury.
20. Prescription Drugs, services or supplies as follows:

- Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
- 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, except when a Medical Necessity.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

21. Reproductive services for the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials and storage of reproductive materials, except as specifically provided in the Policy.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
22. 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.
23. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
24. 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.
25. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
26. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis. This exclusion does not apply to benefits specifically provided in the Policy.
27. Sleep disorders.
28. Speech therapy, except as specifically provided in the Policy. Naturopathic services.
29. 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.
30. Supplies, except as specifically provided in the Policy.
31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy. This exclusion does not apply to breast reduction surgery for treatment of Gender Dysphoria.
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
33. 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).
34. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

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

In the event of Injury or Sickness, students should:

1. Report 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 university under which the student is insured. A Company claim form is not required for filing a claim.

3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

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

By following these instructions, an Insured meets the Notice of Claim provision.

Section 12: General Provisions

GRACE PERIOD: A grace period of 10 days for monthly premium Policies and 31 days for all other Policies will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force.

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. All claims and indemnities payable under the terms of this Policy of accident and health insurance shall be paid within 30 days following receipt by the Company of due proof of loss. Failure to pay within such period shall entitle the Insured to interest at the rate of nine percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

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. An Out-of-Network Provider subject to the *No Surprises Act* may negotiate reimbursement after initial payment is received. If attempts to negotiate reimbursement do not result in a resolution of the payment dispute within 30 days after receipt of the explanation of benefits, then We or the Out-of-Network Provider or facility may initiate binding arbitration. The party requesting arbitration shall notify the other party that arbitration has been initiated and state its final offer before arbitration. In response to this notice, the non-requesting party shall inform the requesting party of its final offer before the arbitration occurs. Arbitration shall be initiated by filing a request with the Department of Insurance.

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: Whenever this Policy has paid benefits because of Sickness or an Injury to any Insured Person resulting from a third party's wrongful act or negligence, to the extent of such payment the Company shall reserve the right to assume the legal claim any Insured Person may have against that third party. This means that the Company may choose to take legal action against the negligent third party or their representatives and to recover from them the amount of claim benefits paid to the Insured Person for loss caused by the third party.

RIGHT OF REIMBURSEMENT: If an Insured Person incurs expenses for Sickness or an Injury that occurred due to the negligence of a third party:

A) The Company has the right to reimbursement for all benefits paid by the Company from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Insured Person, Insured Person's parents, if the Insured Person is a minor, or Insured Person's legal representative as a result of that Sickness or Injury.

B) The Company is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits paid by the Company for that Sickness or Injury.

The Company has the right to reimbursement out of all funds the Insured Person, the Insured Person's parents, if the Insured Person is a minor, or the Insured Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

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.

The Company will not seek reimbursement for overpayment of a claim made to a provider after 12 months from the date of the first payment on the claim.

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. The Insured Person designating a beneficiary retains the right to change that designation unless he/she make the designation irrevocable.

FRAUD OR INTENTIONAL MISREPRESENTATION OF A MATERIAL FACT: The Company will provide at least 30 days advance notice to the Insured that coverage will end on the date We identify in the notice because the Insured committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to an Insured Person's eligibility. The Insured may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

CONFORMITY WITH STATE STATUTES: Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

UNPAID PREMIUM: Upon payment of a claim under this Policy, any premium then due from an Insured and unpaid or covered by any note or written order may be deducted therefrom.

MISSTATEMENT OF AGE: If the age of the Insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

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 of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

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

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

Internal Appeal Process

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

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

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

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

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

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

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

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative within 15 business days after receipt of the required information.

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

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;

d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;

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

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

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

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

Expedited Internal Review Process
The Insured Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:
1. Relating to healthcare services, including but not limited to, procedures or treatments for the Insured with an ongoing course of treatment ordered by a Provider, the denial of which could significantly increase the risk to an Insured's health; or
2. A treatment referral, service, procedure, or other health care services, the denial of which could significantly increase the risk to an Insured's health.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available.
1. Upon receipt of a request for an Expedited Internal Appeal, the Company will notify the Insured Person, Provider, or Insured's Authorized Representative of all information the Company requires to evaluate the appeal. This notice shall be made as soon as possible, but in no event more than 24 hours after the submission of the appeal.
2. The Insured Person or the Authorized Representative shall be notified of the EIR decision no more than twenty-four (24) hours after receipt of the required information.
3. The Company will notify the filing party of its decision orally with a follow-up Written Notice of Determination.

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.

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

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

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

1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days for concurrent or prospective reviews, 60 days for retrospective reviews, and 48 hours for expedited reviews when the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Company fails to strictly adhere to the Internal Appeal process detailed herein; or
4. The Company agrees to waive the exhaustion requirement.

If the Company determines that benefits are no longer Medically Necessary, the Company shall notify the Insured, the Insured's Authorized Representative, if any, and the Insured's Physician in writing of the Insured's right to request an External Review. The Company's notification shall occur within 24 hours following the Adverse Determination.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 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 Director. Upon request of an External Review, the Director shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

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

Illinois Department of Insurance
Office of Consumer Health Insurance
External Review Unit
320 W. Washington St.
Springfield, IL 62767
(877) 850-4740 Toll-free phone
(217) 557-8495 Fax number
Doi.externalreview@illinois.gov Email address

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.

1. Within five business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within one business day after completion of the preliminary review, the Company shall notify the Director, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
3. After receiving notice that a request is eligible for SER, the Director shall, within one business day:

a. Assign an IRO from the Director's approved list;
b. Notify the Company of the name of the assigned IRO; and
c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

4. a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within one business day, advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 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 Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 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 Director, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

An Expedited External Review request may be submitted in writing after an Insured receives notice of the Company's Adverse Determination or Final Adverse Determination. The Insured or the Insured's Authorized Representative, if any, may submit the Expedited External Review request.

An Expedited External Review request may not be submitted if a Substance Use Disorder treatment provider or facility determines that continued treatment is no longer Medically Necessary.

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

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

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

2. Upon receipt of an EER request, the Director shall immediately send a copy of the request to the Company.
3. Upon receipt of a request for an EER, the Company shall immediately review the request to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;

c. The Insured Person has provided all the information and forms necessary to process the request; and
d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

4. Immediately after completion of the review, the Company shall notify the Director, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
5. When a request is complete and eligible for an EER, the Director shall immediately assign an IRO from the Director's approved list and notify the Company of the name of the assigned IRO.
   a. The Company shall immediately provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
   b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6. a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
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; and
   b. Notify the Director, the Company, the Insured Person, and, if applicable, the Authorized Representative.
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.

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

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

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Director.
2. Upon receipt of an SEIER request, the Director shall immediately send a copy of the request to the Company.
3. Within five business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
   b. The recommended or requested health care services or treatment:
      - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
      - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
   c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
      - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      - Standard health care services or treatments are not medically appropriate for the Insured Person;
      - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. The Insured Person's treating Physician:
      - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or

- Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;

e. The Insured Person has exhausted the Company's Internal Appeal Process; and
f. The Insured Person has provided all the information and forms necessary to process the request.

4. Within one business day after completion of the preliminary review, the Company shall notify the Director, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
5. After receiving notice that a request is eligible for SEIER, the Director shall, within one business day:
   a. Assign an IRO from the Director's approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
6. 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. The Company's failure to provide the documents and information will not delay the SEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
7. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
8. 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 SEIER.
   b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
   c. If the Company reverses its decision, the Company shall immediately provide written notification to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
9. Each clinical review shall provide an oral or written opinion to the IRO no later than 20 calendar days after being selected by the IRO.
10. The IRO shall make a decision and provide oral or written notice of its decision within 20 days after receipt of the opinions from each clinical reviewer.
11. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

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

1. An Insured Person or an Authorized Representative may make an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the Director at the time the Insured Person receives:
   a. An Adverse Determination if:
      - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      - The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or

b. A Final Adverse Determination, if:
   - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
   - The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

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

2. Upon receipt of an EEIER request, the Director shall immediately send a copy of the request to the Company.
3. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
   b. The recommended or requested health care services or treatment:
      - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
      - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
   c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
      - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      - Standard health care services or treatments are not medically appropriate for the Insured Person;
      - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. The Insured Person's treating Physician:
      - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
      - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
   e. The Insured Person has exhausted the Company's Internal Appeal Process unless the Insured person is not required to do so as specified in sub-sections 1. a. and b. above; and
   f. The Insured Person has provided all the information and forms necessary to process the request.
4. The Company shall immediately notify the Director, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
   a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Director.
5. After receiving notice that a request is eligible for EEIER, the Director shall immediately:
   a. Assign an IRO from the Director's approved list; and
   b. Notify the Company of the name of the assigned IRO.
6. The Company shall immediately provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
7. a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
8. 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. The Company's failure to provide the documents and information will not delay the EEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Director, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.

9. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
10. 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 EEIER.
    b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
    c. If the Company reverses its decision, the Company shall immediately provide written notification to the Director, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
11. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than five calendar days after being selected by the IRO.
12. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
13. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

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

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

Adverse Determination means:
1. A determination by the Company or its designee utilization review organization that, based upon the information provided, a request for benefits under the Policy upon application of any utilization review techniques does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, or a preexisting condition, and the requested benefit is denied, reduced or terminated;
2. A denial, reduction or termination based on the Company's or its designee utilization review organization 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 or terminates a request for benefits under the Policy; or
4. A rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Adverse Determination includes unilateral determinations that replace the requested health care service with an approval of an alternative health care service without the agreement of the Insured Person or the Insured Person's Physician for the requested health care service, or that condition approval of the requested service on first trying an alternative health care service, either if the request was made under a medical exceptions procedure, or if all of the following are true:
1. The requested service was not excluded by name, description, or service category under the written terms of coverage.
2. The alternative health care service poses no greater risk to the Insured based on Generally Accepted Standards of Medical Practice.
3. The alternative health care service is at least as likely to produce the same or better effect on the Insured Person's health as the requested service based on Generally Accepted Standards of Medical Practice.

Adverse Determination includes determinations made based on any source of health information pertaining to the Insured Person that is used to deny, reduce, replace, condition, or terminate the benefit or payment.
Adverse Determination includes determinations made in response to a request for authorization when the request was submitted by the Physician regardless of whether the Physician gave notice to or obtained the consent of the Insured Person or Authorized Representative to file the request.

Adverse Determination does not include substitutions performed under Section 19.5 or 25 of the Pharmacy Practice Act.

Authorized Representative means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
2. A person authorized by law to provide substituted consent for an Insured Person;
3. An Insured Person's family member or treating health care provider when the Insured Person is unable to provide consent;
4. A health care provider when the Insured Person's Policy requires that a request for a benefit under the Policy be initiated by the health care provider; or
5. In the case of an urgent care request, a health care professional with knowledge of the Insured Person's medical condition.

Concurrent Review means a review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

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, or its designee utilization review organization, 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 or as set forth for any additional authorization or internal appeal process provided by contract between the Company and the Physician. "Final adverse determination" includes determinations made in an appeal of a denial of prior authorization when the appeal was submitted by the health care provider regardless of whether the provider gave notice to or obtained the consent of the covered person or authorized representative to file an internal appeal.

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

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

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

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

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

Illinois Department of Insurance
Office of Consumer Health Insurance
320 W. Washington St.
Springfield, IL 62767
877-527-9431
www.insurance.illinois.gov

Section 14: Online Access to Account Information

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

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

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

Section 15: ID Cards

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

Section 16: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider.
- 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 under this section for Covered Dental Services, as described below, for Insured Persons under the age of 19. Benefits under this section terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the Policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

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

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

Insured Persons must always check the participation status of a provider prior to seeking services. 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 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 of this section.

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

Network Benefits:

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

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

Out-of-Network Benefits:

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

Dental Services Deductible

Benefits for pediatric Dental Services 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.

Refer to the Pediatric Dental Services Schedule of Benefits for a list of Covered Dental Services.

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in the Pediatric Dental Services Schedule of Benefits, benefits are not provided under this section for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in the Pediatric Dental Services Schedule of Benefits.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges. Benefits may be Covered Medical Expenses available under the Policy. Refer to the Certificate of Coverage Medical Expense Benefits.
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. Benefits may be Covered Medical Expenses available under the Policy. Refer to the Certificate of Coverage Medical Expense Benefits.
8. Procedures that are considered to be Experimental or Investigational. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational 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 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. Benefits may be Covered Medical Expenses available under the Policy. Refer to the Certificate of Coverage Medical Expense Benefits.
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. The Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

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 or Investigational 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 through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.

- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy
    - For treating a life threatening dental disease or condition.
    - Provided in a clinically controlled research setting.
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

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

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

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

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

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

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

Section 19: Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

Policy Deductible

Benefits for pediatric Vision Care Services 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.

Refer to the Pediatric Vision Care Services Schedule of Benefits for a list of covered Vision Care Services.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in the Pediatric Vision Care Services Schedule of Benefits, 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 this section in Section 1: Benefits for Pediatric Vision Care Services.

Section 20: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

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

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

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

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

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

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

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

Copayment and/or Coinsurance Amount

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

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

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

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

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

How Do Supply Limits Apply?

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

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

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject 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. For Prescription Drug Products that allow a 90-day fill, the Insured may be required to obtain a limited number of up to 31-day fills until the maintenance dose is established.

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.

Refill Synchronization

Synchronization of prescription drug refills is available, on at least one occasion per Insured Person per Policy Year, provided all of the following conditions are met:

- The prescription drugs are covered by the clinical coverage policy or have been approved by a formulary exceptions process.
- The drugs are maintenance medications as defined by the Policy and have all available refill quantities at the time of synchronization.
- The medications are not Schedule II, III, or IV controlled substances.
- The Insured meets all utilization management criteria to the drugs at the time of synchronization.
- The drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization.
- The drugs do not have special handling or sourcing needs as determined by the Policy, contract, or agreement that require a single prescription fill or refill.
- The Insured agrees to synchronization.

When necessary to permit synchronization, the Company will apply a prorated daily cost sharing rate to any medication dispensed by a Network Pharmacy pursuant to the above requirements.

The Insured Person may access information on these procedures 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 does not 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.

If the Insured chooses to obtain Specialty Prescription Drug Products that are available from a Non-Preferred Specialty Network Pharmacy, the Insured will be subject to the Non-Preferred Specialty Network Pharmacy Copayment an/or Coinsurance.

However, if a non-Designated Pharmacy has entered into an agreement with the Company that it agrees to accept the same terms and conditions applicable to Designated Pharmacies, including reimbursement at the rate applicable to the Designated Pharmacies, including applicable copayment and/or coinsurance, as payment in full, the Insured may receive benefits on the same basis and at the same copayment and/or coinsurance as the Insured would from a Designated Pharmacy.

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. Please see Designated Pharmacies provision above.

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Do Prior Authorization Requirements Apply?

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

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

The Company or its designee will contact the Insured's Physician and the notification criteria will be reviewed with the Insured's Physician prior to approval or denial of the medication.

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 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 Service.

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 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 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. The Prescription Drug List will not be replaced mid-contract year. Please access www.uhcsr.com or call Customer Service at 1-855-828-7716 for the most up-to-date tier placement.

If a Generic drug or Therapeutic Equivalent is unavailable due to a supply issue and dosage cannot be adjusted, coverage will be provided for a Brand-name eligible Prescription Drug Product until supply of the Generic drug or Therapeutic Equivalent is available.

Rebates and Other Payments

We will apply any third-party payments, financial assistance, discounts, product vouchers, or any other reduction in out-of-pocket expenses made by the Insured Person or on the Insured Person's behalf for Prescription Drugs toward the Insured Person's Deductible, Copayments, or cost-sharing responsibility, or Out-of-Pocket Maximum associated with this Policy.

The Company may also receive rebates for certain drugs included on the Prescription Drug List. The Company may pass these rebates on to the Policyholder in the form of reduced future premiums.

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

Definitions

Brand-name means a Prescription Drug 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.
- Where a drug prescribed for the treatment of a type of cancer has not been approved by the FDA for this particular purpose, the Policy will include coverage of such drug, provided:
- The drug was approved by the FDA for the treatment of some kind of cancer.
- The drug has been recognized for the treatment of the specific type of cancer for which it was prescribed in any one of the following established reference compendia:
  - The American Hospital Formulary Service Drug Information.
  - The National Comprehensive Cancer Network's Drugs & Biologics Compendium.
  - The Thomson Micromedex's DrugDex.
  - The Elsevier Gold Standard's Clinical Pharmacology.
  - Other authoritative compendia as identified by the Federal Secretary of Health and Human Services.
- 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 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 the service has significant potential as an effective treatment for that Sickness or Injury.

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

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

Network Pharmacy means a pharmacy that has:

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

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

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

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

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

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

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

Prescription Drug List means a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's review and change. 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.
  - Glucagon emergency kits.

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.

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 and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined to be experimental or investigational. This exclusion does not apply to drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration for that indication, if the drug has been prescribed for the Insured Person who has cancer, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia: (1) the American Hospital Formulary Service Drug Information; (2) National Comprehensive Cancer Network's Drugs & Biologics Compendium; (3) Thomson Micromedex's Drug Dex; (4) Elsevier Gold Standard's Clinical Pharmacology; (5) other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Service; or if not in the compendia, recommended for that particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.
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 Prescription Drug Products that are repackaged, relabeled, or packaged as (a) unit dose(s).
11. Prescription Drug products 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-4.)
15. The following over-the-counter drugs and products:
    - Drugs or products 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 drug or product 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.
    - Over-the-counter continuous glucose monitors.

    The following Prescription Drug Products with over-the-counter alternatives:
    - 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. Such determinations may be made up to six times during a calendar year.
    - 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 specifically provided in the Policy.
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 to another available Prescription Drug Product or pharmaceutical product, 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.
27. Prescription Drug Products prescribed by a provider who is on the Company's list of excluded providers due to fraud, waste, and/or abuse findings.

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 higher of:

- The applicable Copayment and/or Coinsurance at the highest tier as described in the Schedule of Benefits.
- A Coinsurance of 50%.

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 Exception Request 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 exception review. The Insured Person or the Insured Person's representative may request an external exception 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 Exception Request 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 exception request 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.

UNITEDHEALTHCARE INSURANCE COMPANY

Home Office Address: 185 Asylum Street, Hartford, CT 06103-3408

Schedule of Benefits

DePaul University
2026-394-1
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 87.170%
Injury and Sickness Benefits

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

Deductible Preferred Provider	$500 (Per Insured Person, Per Policy Year)
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	$5,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$10,000 (Per Insured Person, Per Policy Year)

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

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

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

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the *Preferred Provider and Out-of-Network Provider Information* section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at certain Preferred Provider facilities by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider. All other Covered Medical Expenses provided by an Out-of-Network Provider at a Preferred Provider facility will be paid at the Preferred Provider Benefit level.

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.

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

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Intensive Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Miscellaneous Expenses	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Routine Newborn Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.		
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Registered Nurse's Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Day Surgery Miscellaneous	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	$25 Copay per visit 100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible
Physiotherapy No visit limits apply. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Medically Necessary services will not be denied or refused solely based on location where services are provided.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
See also Benefits for Cleft Lip and Cleft Palate.		
Medical Emergency Expenses	80% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Diagnostic X-ray Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Radiation Therapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Laboratory Procedures	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Tests & Procedures	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Injections	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Chemotherapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit section for additional information. For insulin drugs, the total amount of Copayments or Coinsurance shall not exceed $35 for an individual prescription of up to a 30-day supply. For a twin-pack of epinephrine injectors, regardless of the type of epinephrine injector, the total amount of Deductible, Copayments, and Coinsurance shall not exceed $60. For prescription inhalers, the total amount of Copayments or Coinsurance shall not exceed $25 for an individual prescription of up to a 30-day supply. See also Benefits for Opioid Antagonists. See also Benefits for Abortifacients and Hormonal Medication, Pre-exposure and Post-exposure Prophylaxis.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $15 Copay per prescription Tier 1 $50 Copay per prescription Tier 2 $75 Copay per prescription Tier 3 20% Coinsurance per prescription Tier 4 up to a 30-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay the same Copay as the Preferred Specialty Network Pharmacy based on the applicable tier. UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	$50 Copay per prescription generic drug $75 Copay per prescription brand-name drug 100% of billed charge up to a 30-day supply per prescription not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Durable Medical Equipment See also Benefits for Customized Orthotic Devices. See also Benefits for Cleft Lip and Cleft Palate.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Consultant Physician Fees	$50 Copay per visit 100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only and surgical removal of complete bony impacted teeth.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Gender Dysphoria Treatment	Paid as any other Sickness	Paid as any other Sickness
Mental Illness Treatment See also Benefits for Mental Health and Wellness Visits. See also Benefits for Treatment Models for Early Treatment of Serious Mental Illness.	**Inpatient:** 80% of Allowed Amount after Deductible **Outpatient office visits:** $25 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: 80% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Allowed Amount after Deductible
Substance Use Disorder Treatment	**Inpatient:** 80% of Allowed Amount after Deductible **Outpatient office visits:** $25 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs**: 80% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of 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
Abortion Care See Benefits for Abortion Care Services.	100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	60% of Allowed Amount after Deductible
Reconstructive Breast Surgery Following Mastectomy See also Benefits for Breast Implant Removal.	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See also Benefits for A1C Testing.	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospice Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Inpatient Rehabilitation Facility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Skilled Nursing Facility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Urgent Care Center	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Allergy Testing and Treatment	Paid as any other Sickness	Paid as any other Sickness
Bariatric Surgery	Paid as any other Sickness	Paid as any other Sickness
Continuous Glucose Monitors Limited to a one month supply when prescribed in accordance with state law. Additional Medically Necessary continuous glucose monitors will be provided as shown in the Diabetes Services benefit.	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible
Hearing Instruments or Hearing Aids Limited to one hearing aid per hearing impaired ear every 36 months.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Infertility Treatment	Paid as any other Sickness	Paid as any other Sickness
Medical Foods	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Oral Surgery	Paid as any other Sickness	Paid as any other Sickness
Surgically Implanted Hearing Devices	Paid as any other Sickness	Paid as any other Sickness
Temporomandibular Joint Disorder See also Benefits for Jaw Care Services.	Paid as any other Sickness	Paid as any other Sickness

UNITEDHEALTHCARE INSURANCE COMPANY

Home Office Address: 185 Asylum Street, Hartford, CT 06103-3408

Pediatric Dental Services Benefits - Schedule of Benefits

DePaul University
2026-394-1

Pediatric Dental Services Deductible $500

The benefits described in this Schedule of Benefits apply to the Pediatric Dental Services Benefits described in the Certificate of Coverage.

Please refer to the Pediatric Dental Services Benefits section of the Certificate of Coverage for additional provisions related to Pediatric Dental Services Benefits.

Benefit Description

Covered Pediatric Dental Services include:

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. 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	50%	50%
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	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**
D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only		
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 D0707 - Intraoral - periapical radiographic image - image capture only	50%	50%
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.	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**
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		
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%	50%
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	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**
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		
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	50%	50%
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	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys 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 - Placement of interim direct 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	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**
D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) 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%
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**
D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy		
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. 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	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**
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) 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)	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**
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. 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 per 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 missing or broken teeth - partial denture per tooth	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**
D5650 - Add tooth to existing partial denture - per tooth 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) 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)	50%	50%
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	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**
D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic		
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 D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal	50%	50%
The following 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	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**
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		
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth 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%

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 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 exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative treatment of dental pain - per visit	50%	50%
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	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**
D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown 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 when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments D6081 - Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing, and increased pocket depths, includes cleaning of the		

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**
implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6089 - Accessing and retorquing loose implant screw per screw D6090 - Repair of implant/abutment supported prosthesis D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment 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 D6122 - Implant supported retainer for metal FPD - noble 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**
D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6180 - Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments D6190 - Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6193 - Replacement of an implant screw 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 D8210 - Removable appliance therapy D8220 - Fixed appliance therapy	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8671 - Periodic orthodontic treatment visit associated with orthognathic surgery 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		

UNITEDHEALTHCARE INSURANCE COMPANY

Home Office Address: 185 Asylum Street, Hartford, CT 06103-3408

Pediatric Vision Care Services Benefits - Schedule of Benefits

DePaul University
2026-394-1

The benefits described in this Schedule of Benefits apply to the Pediatric Vision Care Services Benefits described in the Certificate of Coverage.

Please refer to the Pediatric Vision Care Services Benefits section of the Certificate of Coverage for additional provisions related to Pediatric Vision Care Services Benefits.

Benefit Description

Covered Pediatric Vision Care Services include:

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

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 (consistent with 45 CFR § 92.101(a)(2)). 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។ សូមហៅទូរសព្ទទៅ **1-866-260-2723** សម្រាប់គម្រោងវេជ្ជសាស្ត្រ **1-800-638-3120** សម្រាប់គម្រោងថែទាំធ្មេញ **1-877-816-3596** សម្រាប់គម្រោងថែទាំផ្នែក ឬហៅទូរសព្ទទៅលេខទូរសព្ទដោយមិនគិតថ្លៃ ដែលបានចុះបញ្ជីសមាជិករបស់អ្នក។ (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 número 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).

ໝາຍເຫດ: ທ່ານສາມາດຂໍນາຍແປພາສາເພື່ອເວົ້າກັບທ່ານໝໍໃນເວລາທີ່ທ່ານນັດໝາຍ ຫຼື ກັບພວກເຮົາໄດ້. ຖ້າວ່າທ່ານເວົ້າ **ພາສາລາວ (Lao)**, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ ແລະ ການສື່ສານຟຣີໃນຮູບແບບອື່ນໆ, 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' yáníłti' doodago nihí nihich'į' yáníłti'go ata' halne'í ła' naayíłt'eehgo bíighah. **Diné (Navajo)** bizaad bee yáníłti'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'įįh 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 हामीसँँग आफ्नो डाक्टरसँँग 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** สำหรับการวางแผนด้านอัทษุ **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).