READ YOUR CERFICATE CAREFULLY

2014–2015

Student Injury and Sickness Insurance Plan

NON RENEWABLE ONE YEAR TERM INSURANCE BLANKET ACCIDENT AND HEALTH POLICY

Designed Especially for the Students of

Johnson & Wales University

JOHNSON & WALES UNIVERSITY

UnitedHealthcare
A UnitedHealth Group Company

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Important Cancellation Information – Please read the provision entitled, "Effective and Termination Dates" found on page 1 and "Payment of Premium" on page 26.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at www.uhcsr.com/JWU.

Eligibility

All registered undergraduate day students (both domestic and international), all students enrolled in the Physician's Assistant program, and all international graduate/doctoral students attending Johnson & Wales University, excluding full-time Johnson & Wales employees, taking credit hours are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

Students 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 Named Insured 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 the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Medical Leave of Absence: Johnson & Wales University allows eligible registered day and international graduate students to continue enrollment under the Johnson & Wales University Student Injury and Sickness Insurance Plan while on an approved medical leave of absence for a maximum of 6 months per Policy Year. Medical Leave of Absence Eligibility requirements: Student must currently be enrolled in the University's Student Injury and Sickness Insurance Plan for at least one trimester. Student must have the medical leave of absence form signed by the Director of the Student Health Center or the Counseling Center or their designee. The Student must intend to return to the University and remain a degree-seeking candidate.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2014. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m. July 31, 2015. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

Coverage expires as follows:

Fall	08-01-14	to	12-01-14
Winter	12-02-14	to	03-09-15
Spring	03-10-15	to	07-31-15
Summer	06-01-15	to	07-31-15
Summer 1	06-01-15	to	06-28-15
Summer 2	06-29-15	to	07-31-15

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

Refunds of premiums are allowed only upon entry into the armed forces.

The Policy is a Non-Renewable One Year Term Policy.

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.

Preferred Provider Information

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

UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

"Network Area" means the 50 mile radius around the local school campus the Named Insured is attending.

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

Inpatient Expenses

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

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Out-of-Network Medical Emergency Services

When Medical Emergency Services for a Medical Emergency are provided by an Out of Network Provider, benefits will be based on the billed amount but are subject to the same Copay or Coinsurance amounts that are applicable to Medical Emergency Services provided by a Preferred Provider.

EXAMPLE OF DETERMINATION OF PAYMENT OBLIGATIONS:

Preferred Provider Benefits

Preferred Provider Coinsurance percentage applied to the Preferred Allowance

For example, if the policy pays 90% of Preferred Allowance and the Preferred Allowance is $100; the Company's benefit payment would be 90% x $100 = $90.

The Company would pay $90 and the Insured would be responsible for payment to the Preferred Provider of $10. The billed amount less the Preferred Allowance is an ineligible amount not owed to the Preferred Provider in accordance with an agreement between the Company and provider.

Out-of-Network Benefits

Out-of-Network Coinsurance percentage applied to the Usual and Customary Charge

For example, if the policy pays 80% of Usual and Customary and the Usual and Customary Charge is $100, the Company's benefit payment would be 80% x $100 = $80.

The Company would pay $80 and the Insured would be responsible for payment to the provider of the billed amount less the amount the Company paid.

NOTICE: The Insured's actual costs for Covered Medical Expenses may exceed the stated Coinsurance or Copayment amount because actual provider charges may not be used to determine Policy and Insured payment obligations.

Schedule of Medical Expense Benefits

Platinum
Injury and Sickness Benefits

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

Deductible Out-of-Network	**$250 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Providers	**100% except as noted below**
Coinsurance Out-of-Network	**80% except as noted below**
Out-of-Pocket Maximum	**$1,000 (Per Insured Person, Per Policy Year)**

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Any applicable 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. Please refer to the Medical Expense Benefits – Injury and

Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

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

Outpatient	Preferred Provider	Out-of-Network
Surgery: *(If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.)*	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous: *(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)*	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees:	Preferred Allowance	Usual and Customary Charges
Anesthetist Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance $15 Copay per visit	Usual and Customary Charges
Physiotherapy: *(Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.)*	100% of Preferred Allowance $15 Copay per visit	Usual and Customary Charges
Medical Emergency Expenses: *(Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.) (The Copay/per visit Deductible is in addition to the Policy Deductible and will be waived if admitted to the Hospital.) (See Out-of-Network Medical Emergency Services, page 15.)*	Preferred Allowance $50 Copay per visit	100% of Usual and Customary Charges $50 Deductible per visit
Diagnostic X-ray Services:	Preferred Allowance	Usual and Customary Charges
Radiation Therapy:	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures:	Preferred Allowance	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
Chemotherapy:	Preferred Allowance	Usual and Customary Charges
Prescription Drugs:	UnitedHealthcare Pharmacy (UHCP) $10 Copay per prescription for Tier 1 $25 Copay per prescription for Tier 2 $45 Copay per prescription for Tier 3 up to a 31 day supply per prescription *(Mail order Prescription Drugs through UHCP at 2.5 times the 31 day supply retail copay.) (If a retail UnitedHealthcare Pharmacy agrees to the same rates, terms and requirements associated with dispensing a 90 day supply, then up to a consecutive 90 day supply of a Prescription Drug Product at 2.5 times the copay that applies to a 31 day supply per prescription.)*	Usual and Customary Charges $10 Deductible per prescription for generic drugs $25 Deductible per prescription for brand name up to a 31 day supply per prescription

Other	Preferred Provider	Out-of-Network
Ambulance Services:	Preferred Allowance	100% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees:	100% of Preferred Allowance $15 Copay per visit	Usual and Customary Charges
Dental Treatment: *(Benefits paid on Injury to Sound, Natural Teeth only.)*	100% of Usual and Customary Charges	100% of Usual and Customary Charges
Mental Illness Treatment: *(Institutions specializing in or primarily treating Mental Illness are not covered.)*	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment: *(See Benefits for Treatment of Chemical Dependency)*	Paid as any other Sickness	Paid as any other Sickness
Maternity: *(See Benefits for Maternity Expenses)*	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	80% of Preferred Allowance	Usual and Customary Charges
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services: *(No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.)*	100% of Preferred Allowance	Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy: *(See Benefits for Reconstructive Breast Surgery Following a Mastectomy)*	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services: *(See Benefits for Diabetes)*	Paid as any other Sickness	Paid as any other Sickness
Home Health Care:	Preferred Allowance	Usual and Customary Charges
Hospice Care:	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility:	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility:	Preferred Allowance	Usual and Customary Charges
Urgent Care Center:	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic:	Preferred Allowance	Usual and Customary Charges

Other	Preferred Provider	Out-of-Network
Approved Clinical Trials: *(See Benefits for Covered Clinical Trials)*	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services:	Paid as any other Sickness	Paid as any other Sickness
Medical Supplies *(Benefits are limited to a 31-day supply per purchase.)*	Preferred Allowance	Usual and Customary Charges
Ostomy Supplies:	Preferred Allowance	Usual and Customary Charges

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You cannot refill a prescription until 75% of the applicable supply limit has been used, except under certain circumstances during a state of emergency or disaster.

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com/JWU or call 1-855-828-7716 or the most up-to-date tier status.

$10 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

$25 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$45 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Mail order Prescription Drugs are available at 2.5 times the 31-day supply retail Copay up to a 90 day supply.

If a retail UnitedHealthcare Network Pharmacy agrees to the same rates, terms and requirements associated with dispensing a 90 day supply, then up to a consecutive 90 day supply of a Prescription Drug Product at 2.5 times the copay that applies to a 31 day supply per prescription.

Specialty Prescription Drugs – if you require Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Pharmacy, your benefits will be provided under the Out-of-Network Prescription Drug Benefits.

Designated Pharmacies – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Pharmacy, your benefits will be provided under the Out-of-Network Prescription Drug Benefits.

Additional Exclusions:
In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven, except as specifically provided in the Benefits for Covered Clinical Trials.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.

5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. 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 assigned to Tier-3.)
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. 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 Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Definitions:

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not 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, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse 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, are determined to be any of the following:

1) 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.
2) 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.
3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

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

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

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

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

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

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 including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our 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 assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

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

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call *Customer Service* at 1-855-828-7716.

Prescription Drug List Management Committee means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Restricted Drug means those covered Prescription Drugs or devices for which reimbursement by the Company is conditioned on the prior approval to prescribe the drug or device or on the provider prescribing one or more alternative drugs or devices before prescribing the drug or device in question.

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

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

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

Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available in the Schedule of Benefits.

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, Copayment or per service Deductible amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

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

Inpatient

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

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

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

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

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

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

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

5. **Surgery (Inpatient).**
   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 (Inpatient).**
Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

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 (Outpatient).**
Physician's fees for outpatient surgery.

12. **Day Surgery Miscellaneous (Outpatient).**
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 (Outpatient).**
Assistant Surgeon Fees in connection with outpatient surgery.

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

15. **Physician's Visits (Outpatient).**
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 (Outpatient).**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):

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

17. **Medical Emergency Expenses (Outpatient).**

Only in connection with a Medical Emergency as defined. Benefits will be paid for Emergency Services, as defined, and the facility charge for use of the emergency room and supplies

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

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

19. **Radiation Therapy (Outpatient).**
See Schedule of Benefits.

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

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

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

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

22. **Injections (Outpatient)**
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 (Outpatient).**
See Schedule of Benefits.

24. **Prescription Drugs (Outpatient).**
See Schedule of Benefits.

Other

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

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

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

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part, including foot orthotics custom molded to the Insured. This does not include pre-molded foot orthotics or over-the-counter supportive devices.

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

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

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

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.
Pediatric dental benefits are provided in the Pediatric Dental Services provision.

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

30. **Substance Use Disorder Treatment.**
See Benefits for Treatment for Chemical Dependency.

31. **Maternity.**
Same as any other Sickness. See Benefits for Maternity Expenses.

This policy does not cover all routine, preventive, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

Initial screening at first visit:
- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
- Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test
- Cystic fibrosis screening

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound
Once during second trimester:

- Ultrasound (anatomy scan)
- Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS), non-invasive fetal aneuploidy DNA testing

Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered, except folic acid supplements with a written prescription. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

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

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

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

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

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

36. **Home Health Care.**
Services received from a licensed home health agency that are:

- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person's home.
- Pursuant to a home health plan.

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

Benefits also include Private Duty Nursing services provided by a Registered Nurse or licensed practical nurse when ordered by the Insured's Physician.

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.

37. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less.

All hospice care must be received from a licensed hospice agency.

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

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

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

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

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

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

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

42. **Approved Clinical Trials**.
See Benefits for Covered Clinical Trials.

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

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

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

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

44. **Medical Supplies.**
Medical supplies must meet all of the following criteria:
- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

Benefits are limited to a 31-day supply per purchase.

45. **Ostomy Supplies**
Benefits for ostomy supplies are limited to the following supplies:
- Pouches, face plates and belts.

- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

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

Mandated Benefits

Benefits for Emergency Services

Benefits will be paid the same as any other Sickness or Injury for treatment of a Medical Emergency. The Insured should use emergency services, including calling 911 or other telephone access systems utilized to access pre hospital emergency services when appropriate for treatment of a Medical Emergency.

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

Benefits for Temporomadibular Joint Disorder

Benefits will be paid the same as treatment to any other joint in the body for the treatment of Temporomandibular Joint Disorder ("TMJ"). Procedures will include splinting and use of intraoral prosthetic appliances to reposition the bones. No benefits will be paid for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, root canal or routine dental treatment.

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

Benefits for Cervical Cancer Screening

Benefits will be paid the same as any other Sickness for Examinations and Laboratory Tests for the screening for the early detection of cervical cancer. Benefits shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control and will include the examination, laboratory fee, and the Physician's interpretation of the laboratory results.

Reimbursement for the laboratory fee will be made only if the laboratory meets accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Examinations and laboratory tests" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

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

Benefits for Mammography

Benefits will be paid the same as any other Sickness for Low-dose Screening Mammography according to the following guidelines:

1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this benefit, "at risk" means the following:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30.
2. One baseline mammogram for any woman thirty-five through thirty-nine years of age, inclusive.
3. A mammogram every other year for any woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Physician.
4. A mammogram every year for any woman fifty years of age or older.

Reimbursement will be made only if the facility where treatment is rendered meets the mammography accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician's interpretation of the results of the procedure.

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

Benefits for Surveillance Tests for Women at Risk for Ovarian Cancer

Benefits will be paid the same as any other Sickness for Surveillance Tests for women age 25 and older At Risk for Ovarian Cancer.

“At risk for ovarian cancer” means either: a) having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2) testing positive for a hereditary ovarian cancer syndrome.

“Surveillance tests” mean annual screening using: a) transvaginal ultrasound, and 2) rectovaginal pelvic examination.

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

Benefits for Colorectal Cancer Screening

Benefits will be paid the same as any other Sickness for Colorectal Cancer Screening. Beginning at age 50, benefits will be provided for non-symptomatic Insured Persons for one of the five screening options below:

1. Yearly fecal occult blood test (FOBT); or
2. Flexible sigmoidoscopy every five (5) years; or
3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years; or
4. Double contract barium enema every five (5) years; or
5. Colonoscopy every ten (10) years.

In addition, upon recommendation of the Physician, Medically Necessary benefits will be provided for one or more of the screening options, based on American Cancer Society guidelines regarding family history or other factors, regardless of the age of the Insured.

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

Benefits for Prostate Specific Antigen (PSA) Tests

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician.

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

Benefits for Reconstructive Breast Surgery Following Mastectomy

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery following a Mastectomy. Benefits will be paid for all stages and revisions of Reconstructive Breast Surgery performed on a diseased breast, as well as for prostheses and physical complications in all stages of Mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a Mastectomy is covered without regard to the lapse of time between the Mastectomy and the reconstruction upon approval by the treating Physician.

“Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

“Reconstructive breast surgery” means surgery performed as a result of a Mastectomy to re-establish symmetry between the two breasts, and includes reconstruction of the Mastectomy site, creation of a new breast mound, and creation of a new

nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

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

Benefits for Diabetes

Benefits will be paid the same as any other Sickness for Medically Necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures, used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician or healthcare professional designated by the Physician.

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

Benefits for Anesthesia and Hospitalization for Dental Procedures

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, Insured's with serious mental or physical conditions, and Insured's with significant behavioral problems, where the Physician treating the Insured involved certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

Benefits do not include expenses for dental procedures except as specifically provided in the Schedule of Benefits.

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

Benefits for Bone Mass Measurement

Benefits will be paid the same as any other Sickness for a Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass for Qualified Individuals.

Benefits will be paid for one Bone Mass Measurement every 23 months. Benefits will be paid more frequently when Medically Necessary. Conditions that may be considered Medically Necessary include, but are not limited to: 1) monitoring beneficiaries on long-term glucocorticoid therapy of more than three months and 2) to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

"Bone mass measurement" means a scientifically proven radiologic, radioisotopic, or other procedure performed on a Qualified Individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

"Qualified individual" means any one or more of the following:

1. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
2. An individual with radiographic osteopenia anywhere in the skeleton;
3. An individual who is receiving long-term glucocorticoid (steroid) therapy;
4. An individual who primary hyperparathyroidism;
5. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
6. An individual who has a history of low-trauma fractures; or
7. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

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

Benefits for Prescription Contraceptives

If the Policy provides coverage for prescription drugs or devices, benefits will be paid the same as any other prescription drug or device for any contraceptive drug or device including the insertion or removal and any medical examination associated with the use of such contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a

contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid the same as any other Sickness for outpatient contraceptive services provided by a Physician.

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

Benefits for Newborn Hearing Screening

Benefits will be paid the same as any other Sickness for Physician ordered newborn hearing screening.

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

Benefits for the Treatment of Lymphedema

Benefits will be paid the same as any other Sickness for the diagnosis, evaluation, and treatment of lymphedema including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a Physician.

Gradient Compression Garments:

1. Require a prescription;
2. Are custom-fit for the Insured Person; and
3. Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

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

Benefits for Hearing Aids

Benefits will be paid for one hearing aid per hearing-impaired ear every 36 months for Insureds under 22 years of age when Medically Necessary and ordered by a Physician or audiologist licensed in the state. Coverage includes:

1. Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
2. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Insured Person.
3. Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

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

Benefits for Covered Clinical Trials

Benefits will be paid the same as any other Sickness for participation in phase I, phase II, phase III, and phase IV Covered Clinical Trials by an Insured who meets protocol requirements of the trials and when informed consent is provided.

Only Covered Medical Expenses for the costs of health care services which are a Medical Necessity and associated with participation in a Covered Clinical Trial, including those related health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and Medically Necessary monitoring will be paid and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

No benefits will be provided for non-FDA approved drugs provided or made available to an Insured patient who received the drug during a Covered Clinical Trial after the clinical trial has been discontinued.

The following clinical trial costs are not covered:

1. Costs of services that are not health care services;
2. Cost of services provided solely to satisfy data collection and analysis needs;
3. Costs of services related to investigation drugs and devices; and
4. Costs of services that are not provided for the direct clinical management of the Insured patient.

"Covered Clinical Trials" means phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

1. Involve the treatment of life-threatening medical conditions;
2. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives;
3. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives;
4. Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
5. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and
6. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

In the event a claim contains charges related to services for which coverage is required under this benefit, and those charges cannot be separated from costs related to services that are not covered under this benefit, the Company shall deny the claim.

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

Benefits for Maternity Expenses

Benefits will be paid the same as any other Sickness for Inpatient and outpatient maternity care.

Inpatient benefits will include:

1. A minimum of forty-eight (48) hours of inpatient care following a vaginal delivery for the mother and her Newborn Infant after childbirth; and
2. A minimum of ninety-six (96) hours of inpatient care following a cesarean section for the mother and Newborn Infant after childbirth.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. In the case of a decision to discharge the mother and her Newborn Infant from the Inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, benefits will include Timely Postdelivery Care. Timely Postdelivery Care shall be provided to a mother and her Newborn Infant by a registered nurse, Physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health. Such follow-up care shall be provided in:

1. The home, a provider's office, a Hospital, a birthing center, an immediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or
2. Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

"Timely PostDelivery Care" means health care that is provided:

1. Following the discharge of a mother and her Newborn Infant from the Inpatient setting; and
2. In a manner that meets the health care needs of the mother and her Newborn Infant, which provides for the appropriate monitoring of the conditions of the mother and Newborn Infant, and occurs not later than the 72-hour period immediately following discharge.

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

Benefits for Treatment for Chemical Dependency

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependency.

Benefits will be paid for the necessary care and treatment of Chemical Dependency for services received from any of the following providers:

1. The following units of a Hospital licensed under Article 5 of General Statutes Chapter 131E:
   a. Chemical Dependency units in facilities licensed after October 1, 1984;

b. Medical units;
c. Psychiatric units; and

2. The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
   a. Chemical Dependency units in psychiatric hospital;
   b. Chemical Dependency Hospitals;
   c. Residential Chemical Dependency treatment facilities;
   d. Social setting detoxification facilities or programs;
   e. Medical detoxification or programs; and

3. Duly licensed Physicians and duly licensed practicing psychologists and certified professionals working under the direct supervision of such Physicians or psychologists in facilities described in 1) and 2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984 under Article 2 of General Statutes Chapter 122C.

The term "Chemical Dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

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

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the "Medical Expense Benefits".

For Loss Of:

Life	$5,000
Two or More Members	$5,000
One Member	$2,500
Thumb or Index Finger	$1,250

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

The Accidental Death benefit is payable for the involuntary inhalation of gas and fumes and the involuntary taking of poison.

Definitions

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

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

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

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

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received

from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

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

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

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

EMERGENCY SERVICES means, with respect to a Medical Emergency:

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

HABILITATIVE SERVICES means outpatient occupational therapy, physical therapy and speech therapy prescribed by the Insured Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

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

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Insured Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental Illness. Hospital includes a duly licensed state tax-supported institution as defined in Statute 58-51-40 of the North Carolina Insurance Code.

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

IN-NETWORK COVERED MEDICAL EXPENSES means Covered Medical Expenses that are received under the terms of the policy from providers under contract with or approved in advance by the Company and means Medical Emergency services regardless of the status or affiliation of the provider of such services.

INJURY means bodily injury which is all of the following:

1) directly and independently caused by specific accidental contact with another body or object.
2) unrelated to any pathological, functional, or structural disorder.
3) a source of loss.
4) treated by a Physician within 30 days after the date of accident.
5) sustained while the Insured Person is covered under this policy.

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

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

INSURED PERSON means the Named Insured. The term "Insured" also means Insured Person.

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

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

MEDICAL EMERGENCY means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention would result in any of the following:

1) Placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
2) Serious impairment of bodily functions.
3) Serious dysfunction of any body organ or part.

MEDICAL NECESSITY/MEDICALLY NECESSARY means those services or supplies that are:

1) Provided for the diagnosis, treatment, cure, or relief of a health condition, Sickness, Injury, or disease; and not for experimental, investigational, or cosmetic purposes, except as allowed for covered clinical trials.
2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, Sickness, Injury, disease, or its symptoms.
3) Within generally accepted standards of medical care in the community.
4) Not solely for the convenience of the Insured, the Insured's family, or the provider.
5) The most appropriate supply or level of service which can safely be provided to the Insured.

For Medically Necessary services, the Company may compare the cost effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that

treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

NEWBORN INFANT, ADOPTED OR FOSTER CHILD means any child born of an Insured or placed with an Insured while that person is insured under this policy. Such child will be covered under the policy from the moment of birth or placement for the first 31 days after birth or placement. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, or birth abnormalities including treatment of cleft lip and cleft palate, prematurity and nursery care.

OUT-OF-NETWORK COVERED MEDICAL EXPENSES means non-emergency Covered Medical Expenses that are not received according to the terms of the policy including services from affiliated providers that are received without the approval of the Company.

OUT-OF-NETWORK PROVIDER means a health care provider who has not agreed to accept special reimbursement or other terms for health care services from the Company for health care services on a fee-for-service basis.

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

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

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

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

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

PREFERRED PROVIDER means a health care provider who has agreed to accept special reimbursement or other terms for health care services from the Company for health care services on a fee-for-service basis.

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

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

SICKNESS means sickness, illness or disease of the Insured Person which causes loss while the Insured Person is covered under this 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 this policy's Effective Date will be considered a sickness under this 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 caused by a Chemical Dependency which is the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

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

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions and Limitations

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

1. Learning disabilities.

   This exclusion does not apply to benefits specifically provided in the policy or to any screening or assessment specifically provided under the Preventive Care Services benefit.

2. Circumcision, except as specifically provided for a Newborn Infant during an Inpatient maternity Hospital stay provided under the Benefits for Maternity Expenses.

3. Congenital Conditions, except as specifically provided for:
   - Habilitative Services.
   - Newborn Infants and Adopted or Foster Children

4. 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 this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions of a Newborn Infant and Adopted or Foster Child.

5. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.

6. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.

   This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or benefits specifically provided in Pediatric Dental Services.

7. Elective Surgery or Elective Treatment.

8. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.

9. Health spa or similar facilities. Strengthening programs.

10. Hearing examinations, except as specifically provided in the Benefits for Newborn Hearing Screening. Hearing aids, except as specifically provided in the Benefits for Hearing Aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of an infection or Injury.
    - Any screening or assessment specifically provided under the Preventive Care Services benefit.

11. Hirsutism. Alopecia.

12. 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.

This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit.

13. Services or supplies for the treatment of an occupational Injury or Sickness which are paid under the North Carolina Worker's Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

14. 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.

15. Investigational services, except as specifically provided in the Benefits for Covered Clinical Trials.

16. Lipectomy.

17. Voluntary participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting, except when as a direct result of domestic abuse.

18. 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 or specifically provided in Benefits for Diabetes.
    - Immunization agents, except as specifically provided in the policy. Biological sera.
    - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (2) The Thomson Micromedex DrugDex; (3) The Elsevier Gold Standard's Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.
    - 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.
    - Growth hormones, except for a Newborn Infant, Adopted or Foster Child who requires growth hormones for the treatment of a Congenital Condition.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

19. Reproductive/Infertility services including but not limited to the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
    - Premarital examinations.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.

20. 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 Benefits for Covered Clinical Trials.

21. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.

- To therapeutic contact lenses when used as a corneal bandage.
- To one pair of eyeglasses or contact lenses due to a prescription change following cataract surgery.
- To any screening or assessment specifically provided under the Preventive Care Services benefit.

22. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.

23. Preventive care services, except as 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.

    This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or any North Carolina mandated benefit included under the policy.

24. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.

25. 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.

26. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.

27. 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.

28. Supplies, except as specifically provided in the policy.

29. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.

30. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

31. 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).

32. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit.

General Provisions

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Insured has given the Company written notice of discontinuance.

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 this 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, or to any authorized agent of the Company 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 180 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 this policy for any loss will be paid within 30 calendar days upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than 30 days of receipt of the claim, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Within 30 days of receipt of the claim, the Company may request additional information in order to process all or part of the claim. If the requested additional information is not received within 90 days after the request is made, the Company shall deny the claim and send notice of the denial. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid. Payment of claims not made in accordance with these provisions shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been 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 this policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made. This provision does not apply to recovery of third party liability settlements.

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.

CERTIFICATE OF CREDITABLE COVERAGE: A certificate of creditable coverage will be provided to the Insured at the time coverage ceases under the Policy and upon request on behalf of the Insured made no later than 24 months after the date coverage ended. The certification will be a written certification of the period of creditable coverage of the Insured under the Policy and any waiting period and affiliation period, if applicable, imposed with respect to the Insured for any coverage under the Policy.

Rebates/Inducements

From time to time the Company may offer or provide certain persons who become Insureds with the Company with discounts for goods or services. In addition, the Company may arrange for third party service providers such as pharmacies, optometrists, and dentists to provide discounted goods and services to those persons who become Insureds of the Company. While the Company has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to the Insureds for the provision of such goods and/or services. The Company is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Company is not liable to the Insured for the negligent provision of such goods and/or services by the third party service providers.

FrontierMEDEX: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

Domestic Students: You are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment. If the condition is an emergency, You should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. We will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine and Blood Transfers
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance Payments (when included with Your enrollment in a UnitedHealthcare **Student**Resources health insurance policy)
- Facilitation of Hospital Admission Payments (when Global Emergency Services is purchased as a stand-alone supplement)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services

Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:
(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and FrontierMEDEX ID Number as listed on your Medical ID Card;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

FrontierMEDEX is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in ***My Account*** at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

Nurseline Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed on the ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

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 **My Account** Now" link. Follow the simple, onscreen directions to establish an online account in minutes using your 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 Message Center - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In *Message* Center, 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 Email Preferences* and making the change there.

ID Cards

One way we are becoming greener is to no longer automatically mail out ***ID Cards***. Instead, we will send an email notification when the digital ID card is available to be downloaded from ***My Account***. An Insured student may also use ***My Account*** to request delivery of a permanent ID card through the mail.

UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating Healthcare or Mental Health providers, call the office or facility; view a map.
- Find My Claims – view claims received within the past 60 days for both the primary insured and covered dependents; includes Provider, date of service, status, claim amount and amount paid.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to ***My Account*** as described above and select ***UnitedHealth Allies Plan*** to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service for treatment, or when not in school, to their Physician or Hospital.

2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (insured's insurance company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.

3. Submit claims for payment within 180 days after the date of service or as soon as reasonably possible to be considered for payment. If the Insured doesn't provide this information within one year and 180 days from 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.

Pediatric Dental Services Benefits

Benefits are provided for Covered Dental Services, for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) date the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

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

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

Covered Dental Services

Benefits are eligible 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.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, the Insured Person may 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.

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

Pre-Authorization

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

If a treatment plan is not submitted, the Insured Person will be responsible for payment of any dental treatment not approved by the Company. 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.

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 Services exclusions.

Policy Deductible

Benefits for pediatric Dental Services are subject to the Deductible stated in the policy Schedule of Benefits.

Dental Services Deductible

Benefits for pediatric Dental Services are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is $500 per Insured Person.

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 1 set of films every 6 months.	50 %	50 %
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 film every 60 months.	50 %	50 %
Periodic Oral Evaluation (Checkup Exam) Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays.	50 %	50 %
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 every 6 months.	50 %	50 %
Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	50 %	50 %
Sealants (Protective Coating) Limited to one sealant per tooth every 36 months.	50 %	50 %
Space Maintainers		
Space Maintainers Limited to one per 60 months. Benefit includes all adjustments within 6 months of installation.	50 %	50 %
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50 %	50 %
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50 %	50 %
Periodontal Surgery (Gum Surgery) Limited to one quadrant or site per 36 months per surgical area.	50 %	50 %
Scaling and Root Planing (Deep Cleanings) Limited to once per quadrant per 24 months.	50 %	50 %
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement.	50 %	50 %
Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars Limited to once per tooth per lifetime. Endodontic Surgery	50 %	50 %
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50 %	50 %
Oral Surgery, including Surgical Extraction	50 %	50 %
Adjunctive Services		
General Services (including Emergency Treatment of dental pain) Covered as a separate Benefit only if no other service was done during the visit other than X-rays.General anesthesia is covered when clinically necessary.	50 %	50 %
Occlusal guards for Insureds age 13 and older	50 %	50 %

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Limited to one guard every 12 months.		
Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50 %	50 %
Fixed Prosthetics (Bridges) Limited to once per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50 %	50 %
Removable Prosthetics (Full or partial dentures) Limited to one per consecutive60 months. No additional allowances for precision or semi-precision attachments.	50 %	50 %
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months.	50 %	50 %
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per 24 months.	50 %	50 %
Implants		
Implant Placement Limited to once per 60 months.	50 %	50 %
Implant Supported Prosthetics Limited to once per 60 months.	50 %	50 %
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to once per 60 months.	50 %	50 %
Repair Implant Supported Prosthesis by Report Limited to once per 60 months.	50 %	50 %
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to once per 60 months.	50 %	50 %
Repair Implant Abutment by Support Limited to once per 60 months.	50 %	50 %
Radiographic/Surgical Implant Index by Report Limited to once per 60 months.	50 %	50 %
MEDICALLY NECESSARY ORTHODONTICS		
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.		
Orthodontic Services 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.	50 %	50 %

Section 3: Pediatric Dental Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy. Except as may be specifically provided under Section 2: Benefits for Covered Dental Services, benefits are not provided for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
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. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network 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

Submit claims for payment within 180 days after the date of service or as soon as reasonably possible to be considered for payment. If the Insured doesn't provide this information within one year and 180 days from 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 the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under this endorsement.

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

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

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

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

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

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.

- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary Fees, as defined below.

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

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

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

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

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

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

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

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

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

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

Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.
Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

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

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-800-638-3120. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

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

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

Network Benefits

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

Non-Network Benefits

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

Policy Deductible

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

Benefit Description

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

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

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

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

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

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

Eyeglass Lenses - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.
The following Optional Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

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

Contact Lenses - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

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

Necessary Contact Lenses - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	50% of the billed charge.
• Bifocal		100% after a Copayment of $40.	50% of the billed charge.
• Trifocal		100% after a Copayment of $40.	50% of the billed charge.
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
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	Limited to a 12 month supply.		
• Covered Contact Lens Selection		100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses		100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions
The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

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

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

Section 3: Claims for Pediatric Vision Care Services
When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

Reimbursement for Vision Care Services

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

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- 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

Submit claims for payment within 180 days after the date of service or as soon as reasonably possible to be considered for payment. If the Insured doesn't provide this information within one year and 180 days 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.

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

Notice of Appeal Rights

RESOLUTION OF GRIEVANCE PROCESS

A Grievance is a written complaint submitted by or on behalf of an Insured Person regarding the following:

1. The Company's decisions, policies, or actions related to availability, delivery or quality of health care services;
2. Claims payment, handling or reimbursement for health care services; or
3. The contractual relationship between an Insured Person and the Company.

A Grievance cannot be filed for a decision rendered solely on the basis the policy does not provide benefits for the health care services in question, if the exclusion of the specific service requested is clearly stated in this Certificate.

Grievance Informal Review

An Insured Person may voluntarily request a review of any decision, policy, or action made by the Company that affects the Insured. The Company provides for immediate informal review after an event that causes a dispute.

1. If the Grievance concerns a clinical issue and the informal consideration decision is not in favor of the Insured Person, the request will be treated as a first-level Grievance review. The Company will provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material.
2. If the Grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the Insured, the Company will issue a written decision that includes the availability of the Commissioner's office and the Managed Care Assistance Program for assistance, including the telephone number and address of the office of both.

If the Company is unable to render an informal consideration decision within 10 business days after receipt of the Grievance, the Company on the day the Company determines an informal consideration decision cannot be made before the tenth business day after receipt of the Grievance, the Company will provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material for an Internal Appeal.

First-Level Grievance Review

The Insured Person or their Authorized Representative has the right to submit a Grievance.

The written Grievance review request should include:

1. A statement specifically requesting to submit a Grievance;
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 for the submission of the Grievance; 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 Grievance review process. The written request for an internal Grievance review should be sent to: Claims Appeals, UnitedHealthcare StudentResources, PO Box 809025, Dallas, TX 75380-9025.

Within 3 business days after receiving a Grievance other than a Grievance concerning the quality of clinical care received by the Insured, the Company shall provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material.

For a Grievance concerning the quality of clinical care delivered by the Insured's provider, the Company will provide acknowledgement of the Grievance to the Insured within 10 business days. The acknowledgement shall advise the Insured Person of the following:

1. The Company will refer the Grievance to its quality assurance committee for review and consideration or any appropriate action against the provider; and
2. State law does not allow for a second-level Grievance review for a Grievance concerning quality of care.

The Company shall issue a written decision to the Insured or an Insured's Authorized Representative within 30 days after receiving a Grievance.

Second-Level Internal Grievance Review

An Insured or an Insured's Authorized Representative may submit a request for a second-level Grievance review when not satisfied with the first-level Grievance review decision. The Company shall, within 10 business days after receiving a request for a second-level Grievance review, provide notice of receipt and provide the Insured with the name, address, and telephone number of the Grievance review coordinator and information on how to submit written material.

The second-level review panel will schedule and hold a review meeting within 45 days after receiving a request for a second-level review. The Insured Person shall be notified in writing within at least 15 days before the review meeting date. The Insured Person's right to a full review will not be conditioned on the Insured's appearance at the review meeting.

The Company shall issue a written decision to the Insured or an Insured's Authorized Representative within 7 business days after completing the review meeting.

NOTICE OF APPEAL RIGHTS FOR NONCERTIFICATIONS AND ADVERSE DETERMINATIONS

Internal Appeal of a Noncertification or Adverse Determination

The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal of Noncertification or Adverse Determination within 180 days after receipt of a notice of a Noncertification or Adverse Determination and include the following information:

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.

An expedited internal appeal of a Noncertification or Adverse Determination may be requested by an Insured Person or the Insured's provider only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of an Insured Person or jeopardize the Insured's ability to regain maximum function.
In consultation with a medical doctor licensed to practice medicine in the state of North Carolina, the Company shall provide written notification of the decision to the Insured Person and the Insured's provider:

1. Within 30 days after the request for a nonexpedited appeal; or
2. As soon as reasonably possible, but not later than 4 days after receipt of information justifying the expedited review.

If the decision is not in favor of the Insured Person; the Insured has the right to file an external review request with the Commissioner of the North Carolina Department of Insurance. If the Insured Person has a medical condition where the time frame for completion of an expedited internal review would reasonably be expected to seriously jeopardize the life or health of the Insured Person, the Insured Person may file a request for an expedited external review at the same time the Insured Person files for an expedited internal review. The Commissioner will determine whether the covered person shall be required to complete the internal expedited review before conducting the expedited external review.

Expedited Internal Appeal

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

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: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

North Carolina law provides for the review of Noncertification decisions by an external independent review organization (IRO). Except for cases when the Insured requests an expedited appeal, external review is available to the Insured only after he or she has completed the Company's internal appeal process for Noncertification. The Insured or an Authorized Representative must make a request to the North Carolina Department of Insurance (NCDOI) for an external review with 120 days of the date of the notice of Noncertification or second-level Grievance decision. The NCDOI administers this service at no charge to the Insured and will arrange for the review of the Insured's case by an IRO once the NCDOI establishes that the request is complete and eligible for review.

Expedited External Review

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

1. A Noncertification decision if:
   (i) the Insured Person or the Authorized Representative has filed a request for an expedited appeal of Noncertification; and
   (ii) the Noncertification involves a medical condition for which the timeframe for completing an expedited appeal of Noncertification would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. An appeal decision upholding a Noncertification, if:
   (i) the Noncertification involves a medical condition for which the timeframe for completing an expedited internal review of a Noncertification would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; and
   (ii) the Insured Person or Authorized Representative has filed a request for an expedited internal review of a Noncertification.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
877-885-0231

Questions Regarding Appeal Rights

Contact Customer Service with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
800-767-0700
972-233-8200

Sales/Marketing Services:
UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
727-563-3400
800-237-0903
E-mail: info@uhcsr.com

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the University 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.

This Certificate is based on Policy # 2014-608-11