UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN
NON-RENEWABLE ONE YEAR TERM INSURANCE
BLANKET ACCIDENT AND HEALTH COVERAGE
CERTIFICATE OF COVERAGE

Designed Especially for the Students of

JOHNSON & WALES UNIVERSITY

2023-2024

PLEASE NOTE:

THIS DOCUMENT HAS CHANGED. PLEASE SEE THE BACK COVER FOR DETAILS

This Certificate of Coverage is Part of Policy # 2023-608-11

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

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

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

UnitedHealthcare®

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Important Cancellation Information – Please read the provisions entitled, "Effective and Termination Dates" found on page 1.

Introduction

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

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

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

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

Section 1: Who Is Covered

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

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

All undergraduate day students, both domestic and international, all international graduate students, and any graduate student required to be enrolled under programmatic requirements (e.g., students enrolled in the Physician Assistant Program, on-campus Occupational Therapy Program, Addiction Counseling or Clinical Mental Health Counseling master's degree programs, etc.), registered and attending Johnson & Wales University and taking credit hours (excluding full-time Johnson & Wales University employees) are eligible and enrolled in the plan on a hard waiver basis. Whether a student is "registered" and "attending" shall be determined exclusively by Johnson & Wales University.

Except as otherwise provided herein, the student (Named Insured, as defined in this Certificate) must actively attend classes for at least 31 days after university classes start to remain eligible. If a Named Insured ceases to be eligible within the first 31 days from the start of classes, coverage will be terminated back to the effective date for which coverage is purchased.

Home study, correspondence, and online courses do not fulfill the eligibility requirements. Notwithstanding anything herein, eligibility requirements of students enrolled in the university's in-person programs shall not be impaired based solely on attendance of classes through an online, remote, or virtual learning environment (1) in the case of a declared federal or state public health emergency that would require online, remote, or virtual learning, or (2) in the case of attendance via online, remote, or virtual learning due to an accommodation for a disability granted by the university.

The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2023. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later (subject to eligibility requirements set forth above).

The Master Policy terminates at 11:59 p.m., July 31, 2024. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

If paying premiums by semester coverage expires as follows:

Fall	8-1-23	to	12-31-23
Spring	1-1-24	to	7-31-24

Summer 1	5-1-24	to	7-31-24
Summer 2	6-1-24	to	7-31-24
Summer 3	7-1-24	To	7-31-24

The Insured Person must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Insured Person's premium must be received within 31 days after the coverage expiration date. It is the Insured Person's responsibility to make timely premium payments to avoid a lapse in coverage.

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

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

Section 3: Medical Leave of Absence Eligibility Requirements

A student can enroll in the student health insurance plan while on an approved medical leave of absence from the University for a maximum of one semester if the student was enrolled as an Insured under the student health insurance plan in the prior semester. In addition, if an Insured suffers an Injury or Sickness while meeting the eligibility requirements, that results in the Insured taking a medical leave of absence, coverage will remain in force until the end of the semester for which coverage was purchased. The Insured must have their medical leave of absence approved in writing by the director of the student health center (or similar position, irrespective of the title) or their designee to be eligible. At the time of taking the leave, the Insured must intend to return to Johnson & Wales University and remain a degree-seeking candidate.

Section 4: Extension of Benefits after Termination

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

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

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

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

This plan is a preferred provider organization or "PPO" plan. It provides a higher level of coverage when Covered Medical Expenses are received from healthcare providers who are part of the plan's network of Preferred Providers. The plan also provides coverage when Covered Medical Expenses are obtained from healthcare providers who are not Preferred Providers, known as Out-of-Network Providers. However, a lower level of coverage may be provided when care is received from Out-of-Network Providers and the Insured Person may be responsible for paying a greater portion of the cost.

Preferred Providers in the local school area are:

UnitedHealthcare Options PPO

Preferred Provider Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities.

The easiest way to locate Preferred Providers is through the plan's website at www.uhcsr.com/JWU. The website will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at 1-800-767-0700 for assistance in finding a Preferred Provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Example of Determination of Payment Obligations:

Preferred Provider Benefits

Preferred Provider Coinsurance percentage applied to the Allowed Amount

For example, if the policy pays 90% of Allowed Amount and the Allowed Amount 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 Allowed Amount 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 Allowed Amount

For example, if the Policy pays 80% of Allowed Amount and the Allowed Amount 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.

Section 6: Medical Expense Benefits

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

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

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

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

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

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.**
   See Schedule of Benefits.

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

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.

- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Blood storage and transfusions of blood, plasma, blood plasma expanders and other fluids injected in the bloodstream.
- Supplies.

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

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

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

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

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

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

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

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

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

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

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

Outpatient

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

When these services are performed in a Physician's office, benefits are payable under outpatient Physician's Visits.

12. **Day Surgery Miscellaneous.**

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

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

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

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

Benefits include the following services when performed in the Physician's office:
- Surgery.

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

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment, including chiropractic care.
- Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for: a) the restoration of speech impaired by Sickness, surgery, or Injury; b) certain significant physical Congenital Conditions such as cleft lip and palate; or c) swallowing disorders related to a specific Sickness or Injury. Benefits do not include speech therapy for stammering or stuttering.

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

17. **Medical Emergency Expenses.**
Benefits will be paid for Emergency Services in connection with an Emergency Medical Condition, as defined.

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

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

20. **Laboratory Procedures.**
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Benefits include laboratory procedures billed in relation to blood storage and transfusions of blood, plasma, blood plasma expanders and other fluids injected in the bloodstream. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

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

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

- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.
- Blood storage and transfusions of blood, plasma, blood plasma expanders and other fluids injected in the bloodstream.

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

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

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

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

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.
- Orthotic devices for the correction of positional plagiocephaly, including dynamic cranioplasty (DOC) bands and soft helmets.

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 Natural Teeth.

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

Any dental treatment limitations do not apply to pediatric dental care covered under the Pediatric Dental Services benefits. 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.

Benefits include biofeedback and neuropsychological testing.

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

Benefits include biofeedback and neuropsychological testing.

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

See Benefits for Maternity Expenses.

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 when the Insured Person is homebound due to an Injury or Sickness and needs part-time or intermittent skilled nursing care from a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) and/or other skilled care services like Physiotherapy for short-term rehabilitation therapies. Benefits include private duty nursing that provides more individual and continuous skilled care for an Insured with complicated and/or chronic medical needs. Services from a home health aide are covered only when the care provided supports a skilled service being delivered in the home.

Home health care services must be:
- Medically Necessary.
- Ordered by the Insured's Physician.

Usually, a home health agency coordinates the services ordered by the Insured's Physician.

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

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

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

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

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

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

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

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

42. **Approved Clinical Trials.**
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. Benefits are also available for reasonable and necessary services related to the search for a donor.

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

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

Travel expenses and lodging expenses may be reimbursed based on the Company's guidelines that are available upon request from customer service. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

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

45. **Allergy Testing and Treatment.**
Same as any other Sickness for allergy testing and treatment when ordered by a Physician.

Benefits include allergy serum, allergy shots and Physician visits for allergy shots.

46. **Bariatric Surgery.**
Same as any other Sickness for surgical treatment of morbid obesity.

47. **Infertility Services**.
Benefits are payable for certain services related to the diagnosis, treatment and correction of any underlying causes of Infertility for all Insured Persons.

Benefits are not available for the following:

- Artificial means of conception, including, but not limited to, artificial insemination, in-vitro fertilization (IVF), ovum or embryo Placement, intracytoplasmic sperm injection (ICSI), and gamete intrafallopian transfer (GIFT) and associated services.
- Donor eggs and sperm.
- Surrogate mothers

Infertility means the inability to conceive a child after 12 consecutive months of unsuccessful attempts.

48. **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.

49. **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.

50. **Sexual Dysfunction.**
Benefits are available for certain services related to the diagnosis, treatment and correction of any underlying causes of sexual dysfunction for Insureds. Benefits for Sexual Dysfunction unrelated to organic disease are not covered.

For the purposes of this benefit, Sexual Dysfunction means any of a group of sexual disorders characterized by inhibition either of sexual desire or of the psychophysiological changes that usually characterize sexual response. Included are female sexual arousal disorder, male erectile disorder and hypoactive sexual desire disorder.

51. **Sterilization.**
Benefits are limited to:
- Tubal ligation not covered under the Preventive Care Services benefit.
- Male vasectomy.

52. **Nutritional Counseling.**
Benefits are provided for Covered Medical Expenses incurred for Medically Necessary nutritional counseling services due to a Sickness or Injury.

Section 7: 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 TREATMENT OF BONES AND JOINTS OF THE JAW, FACE OR HEAD

Benefits will be paid for the diagnosis, therapeutic, and surgical procedures involving bones or joints of the jaw, face, or head on the same basis as for procedures involving other bones or joints of the human skeletal structure. The procedures must be Medically Necessary to treat a condition which prevents normal functioning of that particular bone or joint involved and the condition is caused by congenital deformity, Sickness or traumatic Injury.

Procedures for the treatment of conditions of the jaw (temporomandibular joint disorder) 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 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 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 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 for the treatment of Chemical Dependency as specified in the Policy Schedule of Benefits for Substance Use Disorder Treatment.

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 hospitals;
   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.

BENEFITS FOR OFF-LABEL DRUG USE

Benefits will be paid the same as any other Prescription Drug for any drug prescribed to treat an Insured Person for the treatment of cancer if the drug meets the following requirements:

1. Has been approved by the Food and Drug Administration for use.
2. Proven effective and accepted for the treatment of a specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:
   a. The National Comprehensive Cancer Network Drugs & Biologics Compendium.
   b. The ThomsonMicromedex DrugDex.
   c. The Elsevier Gold Standard's Clinical Pharmacology.
   d. Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

Benefits do not include experimental drugs used for the treatment of cancer if the drug has not been approved by the Food and Drug Administration or use of a drug that is contraindicated by the Food and Drug Administration.

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

Preventive Care Services

The following state mandated benefits are also federally required Preventive Care Services.

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:
1. 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:
1. 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 45, 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 contrast 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 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

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.

Section 8: 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	$5,000.00
Two or More Members	$5,000.00
One Member	$2,500.00
Thumb or Index Finger	$1,250.00

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.

Section 9: Definitions

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

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

Allowed amounts are based on the following:

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

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

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

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

2. **For Emergency Services provided by an Out-of-Network Provider**, the allowed amount is based on one of the following in the order listed below as applicable:
   - The reimbursement rate as determined by a state *All Payer Model Agreement*.
   - The reimbursement rate as determined by state law.

- The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
- The amount determined by *Independent Dispute Resolution (IDR)*.

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

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

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

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

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

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

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

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

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

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

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

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

7. In excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance 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 the Policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

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

EMERGENCY MEDICAL CONDITION means a medical condition (including Mental Illness and Substance Use Disorder) 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.

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

EMERGENCY SERVICES means, health care items and services furnished or required to screen for or treat an Emergency Medical Condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department. Emergency services include both:

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

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

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

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

ESSENTIAL HEALTH BENEFITS means the following general categories and the items and services covered within the categories:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

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

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

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

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

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

INJURY means bodily injury which is all of the following:

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

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

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

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

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

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

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

MEDICAL NECESSITY/MEDICALLY NECESSARY means those services or supplies that are all of the following:

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 relieve of the 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 disorder in the *Diagnostic and Statistical Manual of Mental Disorders, DSM-5,* or subsequent editions published by *the American Psychiatric Association,* except those mental disorders coded in the DSM-5 or subsequent edition, substance-related disorders (291.0 through 292.2 and 303.0 through 305.9), those coded as sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

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

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.

NEWBORN INFANT, ADOPTED OR FOSTER CHILD means any child born of an Insured or placed with an Insured while that person is insured under the 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 provider who does not have a contract with the Company to provide services to Insured Persons.

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

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

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

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

POLICY OR MASTER POLICY means the entire agreement issued to the Policyholder that includes all of the following:

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.
4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

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

POLICYHOLDER means the institution of higher education to whom the Master Policy is issued.

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

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

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

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

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

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

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

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

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

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

SICKNESS means sickness, illness or disease of the Insured Person which causes loss while the Insured Person is covered under the Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one

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

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

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.

TELEHEALTH/TELEMEDICINE means live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work.

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

Section 10: Exclusions and Limitations

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

1. 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. Cosmetic procedures, except:
   - To treat or correct Congenital Conditions of a Newborn Infant and Adopted or Foster Child.
   - Reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
5. Dental treatment, except:
   - For accidental Injury to 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.
6. Elective Surgery or Elective Treatment.
7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
8. Health spa or similar facilities. Strengthening programs.
9. 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.
10. 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.
11. Investigational services, except as specifically provided in the Benefits for Covered Clinical Trials.
12. Lipectomy.
13. 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.
14. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy for Medical Supplies or as specifically provided in Benefits for Diabetes.
    - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs. This exclusion does not apply to Prescription Drugs used in covered phases I, II, III and IV clinical trials or 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.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

15. Reproductive services for the following, except as specifically provided in the Policy for Infertility Services:
    - Procreative counseling.
    - Genetic counseling and genetic testing, except for high risk patients when the therapeutic or diagnostic course would be determined by the outcome of the testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Premarital examinations.
    - Reversal of sterilization procedures.
16. 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.
17. 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.
18. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
19. Preventive care services which are not specifically provided in the Policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.

    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.
20. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
21. 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.
22. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
23. Speech therapy for stammering or stuttering. Holistic medicine services performed by any Physician or provider.
24. Supplies, except as specifically provided in the Policy.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
28. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Care Services benefit, or benefits specifically provided in the Policy.

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

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service for treatment, or when not in school, to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/MyAccount or submit claims by mail. If submitting by mail, send to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the 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.

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

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

Section 12: General Provisions

GRACE PERIOD: A grace period of 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 the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025, 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 the 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 the Policy may, at the Company's option, be paid directly to the Hospital or person rendering such service, unless the Named Insured requests otherwise in writing not later than 30 days of receipt of the claim. 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. 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.

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

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

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

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

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.

Section 13: 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.

Section 14: Grievance Procedures

An Insured Person may voluntarily request a review of any decision, policy, or action made by the Company that affects the Insured through the Grievance Review Process. An Insured Person may not submit a Grievance for a decision rendered by the Company solely on the basis that the policy does not provide benefits for the health service in question.

The Insured may contact the North Carolina Department of Insurance for assistance with Grievance Procedures at:

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free Telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
https://www.ncdoi.gov/consumers/health-insurance

External Review and Request Form:
https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

For main website:
https://www.ncdoi.gov/

Grievance Review Procedures

First-Level Grievance Review

The Insured Person or their Authorized Representative has the right to submit all Grievances to the Company for review. 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 Student Resources, PO Box 809025, Dallas, TX 75380-9025.

An Insured or an Insured's Authorized Representative may submit all Grievances to the Company for review. Within three 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 shall provide acknowledgement of the Grievance to the Insured within 10 business days advising 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. North Carolina state law does not allow for a second-level Grievance review for a Grievance concerning quality of care.

The Grievance will not be reviewed by the same person or persons who initially handled the matter that is the subject of the Grievance. If the Grievance is of a clinical issue, at least one of the person or persons reviewing the Grievance shall be a medical doctor with appropriate expertise to evaluate the matter.

The Company shall issue a written decision to the Insured or the Insured's Authorized Representative within 30 days after receiving a Grievance. The written decision issued in a first-level Grievance review shall contain:

1. The professional qualifications and licensure of the person or persons reviewing the Grievance;
2. A statement of the reviewer's understanding of the Grievance;
3. The reviewer's decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position;
4. A reference to the evidence or documentation used as the basis for the decision;
5. A statement advising the Insured Person of the their right to request a second level Grievance review and a description of the procedure for submitting a second level Grievance; and
6. Notice that the Health Insurance Smart NC is available for assistance through the North Carolina Department of Insurance at:

   By Mail:
   North Carolina Department of Insurance
   Health Insurance Smart NC
   1201 Mail Service Center
   Raleigh, NC 27699-1201
   Toll free telephone: (855) 408-1212

   In Person:
   For the physical address for Health Insurance Smart NC, please visit the webpage:
   https://www.ncdoi.gov/consumers/health-insurance

   External Review and Request Form:
   https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

   For main website:
   https://www.ncdoi.gov/

Second-Level 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. This second-level review is not available for Grievances concerning quality of care.

The Company shall, within 10 business days after receiving a request for a second-level Grievance review, provide notice of the following information:

1. The name, address, and telephone number of the designated person coordinating the Grievance review for the Company;
2. A statement of the Insured Person's rights, including the right to:
   a. Request and receive from the Company all information relevant to the case;
   b. Attend the second-level Grievance review;
   c. Present his or her case to the review panel;
   d. Submit supporting materials before and at the review meeting,
   e. Ask questions of any member of the review panel; and
   f. Be assisted or represented by a person of his or her choice, which may be without limitation to a provider, family member, employer representative, or an attorney. If the Insured Person chooses to be represented by an attorney, the Company may also be represented by an attorney.
3. Notice that the Health Insurance Smart NC is available for assistance through the North Carolina Department of Insurance at:

   By Mail:
   Health Insurance Smart NC
   North Carolina Department of Insurance
   1201 Mail Service Center
   Raleigh, NC 27699-1201
   Toll free telephone: (855) 408-1212

   In Person:
   For the physical address for Health Insurance Smart NC, please visit the webpage:
   https://www.ncdoi.gov/consumers/health-insurance

   External Review and Request Form:
   https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

   For main website:
   https://www.ncdoi.gov/

The Company shall convene a second-level Grievance review panel for each request. The panel shall be comprised of persons who were not previously involved in any matter giving rise to the second-level Grievance review, are not employees of the Company, and do not have a financial interest in the outcome of the review. All persons reviewing a second-level Grievance involving clinical issue must be providers who have appropriate expertise, including at least one clinical peer. When the second-level review panel is comprised of three persons or more and a clinical peer was used on the first-level Grievance review panel, the Company may use one of the Company's employees on the second-level Grievance review panel in place of a clinical peer.

The second-level review panel shall 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 seven business days after completing the review meeting. The decision shall include:

1. The professional qualifications and licensure of the members of the review panel;
2. A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
3. The review panel's recommendation to the Company and the rationale behind the recommendation;
4. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation;
5. The rationale for the Company's decision if the decision differs from the review panel's recommendation.
6. A statement that the decision is the Company's final determination in the matter;

7. Notice of the availability of the Commissioner's office for assistance; including the telephone number and address of the Commissioner's office; and
8. Notice that the Health Insurance Smart NC is available for assistance through the North Carolina Department of Insurance at:

By Mail:
Health Insurance Smart NC
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free Telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
https://www.ncdoi.gov/consumers/health-insurance

External Review and Request Form:
https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

For main website:
https://www.ncdoi.gov/

Grievance Procedures Definitions

For the purpose of this Grievance Procedure provision, the following terms are defined as shown below:

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

Grievance means a written complaint submitted by or on behalf of an Insured Person regarding:
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.

Grievance" does not mean 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 the certificate of coverage.

Section 15: Notice of Utilization Reviews and Internal Appeal and External Independent Review Procedures for NonCertifications and Adverse Determinations

Utilization Review

Prospective and Concurrent Utilization Review determinations shall be communicated to the Insured Person's provider within three business days after the Company obtains the necessary information about the admission, procedure, or health care service. Necessary information includes the results of any patient examination, clinical evaluation, or second opinion that may be required.

1. If the Company certifies the health care service, the Company will notify the Insured Person's treating provider.
2. For a Noncertification, the Company will notify the Insured Person's treating provider and send written or electronic confirmation of the Noncertification to the Insured Person. For Concurrent reviews, until the Insured Person receives notification of the Noncertification, the Company will remain liable for the health care services.

For Retrospective Reviews, the Company will make the determination within 30 days of the request for noncertification review.

1. When the heath care service is certified, the Company will provider written notice to the Insured Person's treating provider.
2. Within 5 business days of making the determination of Noncertification, the Company will provide written notice to the Insured Person and the Insured's provider.

A written notification of a Noncertification shall include all reasons for the Noncertification, including the clinical rationale and instructions on how to initiate a voluntary internal appeal for the Noncertification. The notification shall include information on the availability of assistance from the Health Insurance Smart NC, including the telephone number and address of the Program and include a notice of the Insured Person's right to file an external review with the Commissioner of the North Carolina Department of Insurance. The notice shall also include a statement explaining that 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 notice shall also explain that the Commissioner will determine whether the covered person shall be required to complete the internal expedited review before conducting the expedited external review.

The Company shall provide the clinical review criteria used to make the Noncertification to any person who received the notification of the Noncertification and who follows the procedures for a request.

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

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

The written Internal Appeal request should include:

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

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

Internal Appeal Process
Within 180 days after receipt of a notice of a Noncertification or Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of a Noncertification or Adverse Determination. The Insured Person or an Authorized Representative is allowed to review the Insured Person's file, present evidence and testimony as part of the internal appeal process. The Insured Person will receive continued coverage in relation to the Noncertification or Adverse Determination pending the outcome of the internal appeal. This internal appeal process is free of charge to the Insured Person.

Within three calendar days after receiving a request for a standard, nonexpedited internal appeal, the Company shall provide the Insured Person with the name, address and telephone number of the coordinator and information on how to submit written material.

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 three calendar days after receipt of information justifying the expedited review.

If the decision is not in favor of the Insured Person, the final written appeal decision shall contain the following information:

1. Information identifying the claim, including the following:
    a. The date of service;
    b. The health care provider; and

c. The claim amount;

2. A statement describing the availability of the diagnosis code and treatment code and their corresponding meaning, upon request;
3. The professional qualifications and licensure of the person(s) reviewing the appeal;
4. A statement of the reviewer's understanding of the reason for the Insured's appeal;
5. The reviewer's decision in clear terms and the medical rationale in sufficient detail for the Insured to respond further to the Company's decision;
6. A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria;
7. The following statement disclosing the availability and contact information for Health Insurance Smart NC:

   Services provided by the Health Insurance Smart NC are available through the North Carolina Department of Insurance. To reach this Program, contact:

   By Mail:
   Health Insurance Smart NC
   North Carolina Department of Insurance
   1201 Mail Service Center
   Raleigh, NC 27699-1201
   Toll free Telephone: (855) 408-1212

   In Person:
   For the physical address for Health Insurance Smart NC, please visit the webpage:
   https://www.ncdoi.gov/consumers/health-insurance

   External Review and Request Form:
   https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

   For main website:
   https://www.ncdoi.gov/

8. The Insured Person's right to file an external review with the Commissioner of the North Carolina Department of Insurance, including the telephone number and address of the Commissioner.
9. A statement explaining that 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. And 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 Review
For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Review (EIR).

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

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

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

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

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

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized Representative shall be notified of the EIR decision no more than twenty-four (24) hours after the Company's receipt of the EIR request.

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

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

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

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

External Independent Review

North Carolina law provides for review of Noncertification or Adverse Determination decisions by an external, independent review organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to the Insured, arranging for an IRO to review the Insured's case once the NCDOI establishes that the request is complete and eligible for review. The Company will notify the Insured in writing of their right to request an external review each time a Noncertification decision or an appeal decision upholding a Noncertification decision. Within 120 days after the date of receipt of the above notifications, the Insured Person may file a request with the Commissioner of the NCDOI for an external review.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review. Rescissions of coverage are not eligible for External Review in the state of North Carolina but will be reviewed at the Internal Appeals level.

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

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
https://www.ncdoi.gov/consumers/health-insurance

External Review and Request Form:
https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

For main website:
https://www.ncdoi.gov/

Standard External Review (SER) Process
In order for the request to be eligible for external review, the NCDOI must conduct a preliminary review to determine the following:

1. The Insured has provided all information and forms required by the Commissioner necessary to process an external review;
2. The Insured had coverage with the Company in effect when the Noncertification or Grievance decision was issued;
3. The service for which the Noncertification was issued appears to be a covered service under the policy; and
4. The Insured has exhausted the Company's internal review processes as described above.

The Insured will be considered to have exhausted the internal review process if the Insured has:

1. completed the Company's internal appeal of Noncertification process and received a written determination from the Company; or
2. filed an Internal appeal and except to the extent that the Insured has requested or agreed to a delay; has not received the Company's written decision within 60 days of the date the request was submitted or has received notification from the Company agreeing to waive the requirement to exhaust the internal appeal of Noncertification.

Upon receipt of a request for a SER, the Commissioner, within 10 business days:

1. Notify and send a copy of the request to the Company and require the Company to provide, within three business days or receipt of notice, any information the Commissioner requires to conduct the preliminary review;
2. Conduct a preliminary review;
3. Notify the Insured Person and the Insured Person's provider who performed or requested the service whether the request is complete and has been accepted for SER;
    a. If the preliminary review finds that the request for SER is not complete, the Commissioner will request the Insured to furnish, within 150 days after the date of the Company's decision for which the SER was requested, the information or materials needed to make the request complete; or
    b. If the preliminary review finds that the request for SER is not accepted for external review, the Commissioner will notify in writing the Insured Person, the Insured Person's provider who performed or requested the service, and the Company of the reasons for its nonacceptance.
4. Assign the review to an IRO;
5. Forward to the assigned IRO any documents that were received relating to the request for a SER;
6. Notify the Company in writing whether the request for SER has been accepted. If the request has been accepted, the notice shall direct the Company to provide the IRO and the Insured or the Insured's Authorized Representative, within seven business days, with the documents and any information considered in making the Noncertification appeal decision;
7. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Noncertification appeal decision. Upon making this decision, the IRO shall, within one business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
8. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
9. If the Commissioner receives any additional information from the Insured Person or the Authorized Representative, the Commissioner will forward the information to the IRO within two business day or receiving it and shall forward a copy of the information to the Company.
    a. The Company may then reconsider its Noncertification appeal decision subject to the SER. Reconsideration by the Company shall not delay or terminate the SER.
    b. The SER may only be terminated if the Company decides to reverse its Noncertification appeal decision and provide coverage for the service that is the subject of the SER.
    c. If the Company reverses it decision, the Company shall provide written notification within one business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
10. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Noncertification appeal decision. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative.

Upon receipt of a notice of decision reversing the Noncertification appeal decision, the Company shall, within three business days, provide coverage or payment for the requested health care service or supply that was the subject of the Noncertification appeal decision.

If the Insured Person is no longer covered by the Company at the time the Company receives notice of the IRO's decision to reverse the Noncertification, the Company will only provide coverage for those services or supplies the Insured actually received or would have received prior to disenrollment if the service had not been Noncertified when first requested.

Expedited External Review (EER) Process

The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the NCDOI at the time the Insured Person receives:

1. A Noncertification decision if:
    a. the Insured Person or the Authorized Representative has filed a request for an expedited appeal of Noncertification; and

b. 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:
   a. 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
   b. the Insured Person or Authorized Representative has filed a request for an expedited internal review of a Noncertification.

An EER may not be provided for Retrospective Noncertifications.

Upon receipt of a request for an EER, the Commissioner, within three calendar days shall:

1. Notify and send a copy of the request to the Company and require the Company to provide, within one day after receiving the notice any information the Commissioner requires to conduct the preliminary review;
2. Conduct a preliminary review;
3. Notify the Insured Person and the Insured Person's provider who performed or requested the service whether the request is complete and has been accepted for SER;
4. For an EER made involving an Insured with a medical condition for which the timeframe for completing a review other than an EER could seriously jeopardize the life or health of the Insured or jeopardize the Insured's ability to regain maximum function; determine, based on medical advice from a medical professional not affiliated with the IRO that will be assigned to conduct the EER, whether the request should be reviewed on an expedited basis.
5. Notify the Insured Person and the Insured Person's provider who performed or requested the service whether the request is complete and has been accepted for an EER.
6. Assign the EER to an IRO, if the request is determined to be accepted for an EER;
7. If the request is determined to not be accepted for an EER, notify the Insured or the Insured's Authorized Representative and the Insured's provider whether the review will be conducted using an expedited or standard time frame or if the Insured must exhaust the Company's internal appeal process before making another request for an external review with the Commissioner.
8. If the request is determined accepted for an EER, forward to the assigned IRO any documents that were received relating to the request for a EER;
9. Notify the Company in writing whether the request for SER has been accepted. If the request has been accepted, the notice shall direct the Company to provide the IRO and the Insured or the Insured's Authorized Representative, within the same day as receiving notification of acceptance of the request for EER, with the documents and any information considered in making the Noncertification or Adverse Determination appeal decision;
10. In no more than three days after receipt of the qualifying EER request, the IRO shall:
    a. Make a decision to uphold or reverse the Noncertification, Noncertification appeal decision; or Adverse Determination and
    b. Notify the Insured Person or the Authorized Representative; the Insured's provider, the Commissioner, and the Company.
11. If the notice of decision was not provided in writing, within two days after the date of providing the notice, the IRO shall provide written confirmation of the decision to the Insured Person or Authorized Representative, the Insured's provider, the Commissioner, and the Company

Upon receipt of a notice of decision reversing the Noncertification, Noncertification appeal decision, or Adverse Determination, the Company shall immediately, within one business day, approve the coverage that was the subject of the Noncertification, Noncertification appeal decision, or Adverse Determination.

BINDING EXTERNAL REVIEW

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

APPEAL RIGHTS DEFINITIONS

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

Adverse Determination means:

1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of

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

Ambulatory Review means Utilization Review of services performed or provided in an outpatient setting.

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

Case Management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

Certification means a determination by the Company or its designated Utilization Review Organization that an admission, availability of care, continued stay, or other service has been reviewed an, based on the information provided, satisfies the Company's requirements for Medically Necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.

Concurrent Review means Utilization Review conducted during an Insured's hospital stay or course of treatment.
Discharge Planning means the formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.

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

Noncertification means a determination by the Company or its designated Utilization Review Organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage under the Benefits for Emergency Services, and the requested service is therefore denied, reduced, or terminated. A "Noncertification" includes any situation in which the Company or its designated Utilization Review Organization makes a decision about an Insured Person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the policy is affected by that decision. "Noncertification" does not mean 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 the certificate of coverage.

Prospective Review means Utilization Review conducted before an admission or a course of treatment including any required preauthorization or precertification.

Retrospective Review means Utilization Review of Medically Necessary services and supplies that are conducted after services have been provided to a patient not the review of a claim that is limited to the veracity of documentation, accuracy of coding or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard under the Benefits for Emergency Services has been met.

Second Opinion means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or

2. In the opinion of a physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include Ambulatory Review, Prospective Review, Second Opinion, Certification, Concurrent Review, Case Management, Discharge Planning, or Retrospective Review.

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

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

By Mail:
North Carolina Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
Toll free telephone: (855) 408-1212

In Person:
For the physical address for Health Insurance Smart NC, please visit the webpage:
https://www.ncdoi.gov/consumers/health-insurance

External Review and Request Form:
https://www.ncdoi.gov/consumers/health-insurance/health-claim-denied/request-external-review

For main website:
https://www.ncdoi.gov/

Section 16: Online Access to Account Information

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

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

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

Section 17: ID Cards

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

Section 18: UHCSR Mobile App

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

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

Section 19: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

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

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

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

Schedule of Benefits

Johnson & Wales University

2023-608-11

METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 90.970%

Injury and Sickness Benefits

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

Deductible Preferred Provider	$100 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$300 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	90% except as noted below
Coinsurance Out-of-Network Provider	70% except as noted below
Out-of-Pocket Maximum Provider	$8,500 (Per Insured Person, Per Policy Year)

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

The **Preferred Provider** for this plan is UnitedHealthcare Options PPO.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. “Network area” means the 50 mile radius around the local school campus the Named Insured is attending.

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

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays.

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

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.

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	Allowed Amount after Deductible	Allowed Amount after Deductible
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care	Paid any other Sickness	Paid as any other Sickness

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

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

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital. See Out-of-Network Provider Benefits, page 3.	Allowed Amount after Deductible	90% of Allowed Amount after Deductible
Diagnostic X-ray Services	100% of Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	100% of Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Tests & Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $10 Copay per prescription Tier 1 20% Coinsurance per prescription Tier 2 20% Coinsurance per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the 31-day supply retail Copay and/or Coinsurance (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the 31-day supply retail Copay or 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 at 2.5 times the Copay and/or Coinsurance that applies to a 31-day supply per prescription.	$10 Copay per prescription generic drug $25 Copay per prescription brand-name drug 80% of billed charge up to a 31-day supply per prescription not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	$50 Copay per trip 100% of Allowed Amount not subject to Deductible	$50 Copay per trip 100% of Allowed Amount not subject to Deductible
Durable Medical Equipment	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Dental Treatment Benefits paid on Injury to Natural Teeth only.	Allowed Amount after Deductible	90% of Allowed Amount after Deductible
Mental Illness Treatment	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Substance Use Disorder Treatment See Benefits for Treatment for Chemical Dependency	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Maternity See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	80% of Allowed Amount after Deductible	Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospice Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Inpatient Rehabilitation Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Skilled Nursing Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	Allowed Amount after Deductible	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
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
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Allergy Testing and Treatment	Paid as any other Sickness	Paid as any other Sickness
Bariatric Surgery	Paid as any other Sickness	Paid as any other Sickness
Infertility Services	Paid as any other Sickness	Paid as any other Sickness
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Allowed Amount after Deductible	Allowed Amount after Deductible
Ostomy Supplies Benefits are limited to a 31-day supply per purchase.	Allowed Amount after Deductible	Allowed Amount after Deductible
Sexual Dysfunction	Paid as any other Sickness	Paid as any other Sickness
Sterilization	Paid as any other Sickness	Paid as any other Sickness
Nutritional Counseling	Paid as any other Sickness	Paid as any other Sickness

UNITEDHEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

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

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

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

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

Insured Persons must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. The Insured Person can check the participation status by calling the Company and/or the provider. The Company can help in referring the Insured Person to Network Dental Providers.

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

Out-of-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services from out-of-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. When the Insured Person obtains Covered Dental Services from out-of-Network Dental Providers, the Insured Person must file a claim with the Company to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

The Insured Person is eligible for benefits for Covered Dental Services listed in this endorsement if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service under this endorsement.

What Is a Pre-Treatment Estimate?

If the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, the Insured Person may notify the Company of such treatment before treatment begins and receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

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

Does Pre-Authorization Apply?

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

Section 2: Benefits for Pediatric Dental Services

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

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

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

Network Benefits:

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

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

Out-of-Network Benefits:

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

Dental Services Deductible

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

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

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefit Description

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Diagnostic Services - (Subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient The following service is not subject to a frequency limit. D0160 - Detailed and extensive oral evaluation - problem focused, by report	50%	50%
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Intraoral complete series of radiographic images D0709 - Intraoral - complete series of radiographic images - image capture only	50%	50%
The following services are not subject to a frequency limit.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only		
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0708 - Intraoral - bitewing radiographic image - image capture only	50%	50%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only D0704 - 3-D Photographic image - image capture only	50%	50%
The following service is limited to 2 images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%	50%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0470 - Diagnostic casts	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only		
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to 2 times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%	50%
Fluoride Treatments The following services are limited to 2 times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish	50%	50%
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%	50%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant		
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of 1 time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2740 - Crown - porcelain/ceramic D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following services are limited to 1 time per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth D2950 - Core buildup, including any pins when required	50%	50%
The following service is limited to 1 time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to restoration	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D3220 - Therapeutic pulpotomy (excluding final restoration)		
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%	50%
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) – anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3310 - Endodontic therapy anterior tooth (excluding final restoration) D3320 - Endodontic therapy premolar tooth (excluding final restoration) D3330 - Endodontic therapy molar tooth (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy (each additional root) D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar		
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following services are limited to 1 every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard tissue	50%	50%
The following services are limited to 1 every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D4263 - Bone replacement graft retained natural tooth - first site in quadrant		
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure	50%	50%
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns	50%	50%
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%	50%
The following service is limited to a frequency to 1 per lifetime. D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit	50%	50%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
retentive/clasping materials, rests, and teeth) - per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture (each tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture	50%	50%
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)		
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic	50%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are limited to 1 time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal		
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond FPD	50%	50%
The following service is not subject to a frequency limit. D6980 - FPD repair necessitated by restorative material failure	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root	50%	50%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%	50%
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess, intraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D9110 - Palliative (Emergency) treatment of dental pain - minor procedure		
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration	50%	50%
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
The following is limited to 1 guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to 1 time every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement: transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6095 - Repair implant abutment, by report D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant replacement D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular	50%	50%

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this endorsement 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. Benefits may be Covered Medical Expenses available under the Policy. Refer to the Medical Expense Benefits section of the Certificate.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision. Benefits may be Covered Medical Expenses available under the Policy. Refer to the Medical Expense Benefits section of the Certificate.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this endorsement to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from an out-of-Network Dental Provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

Reimbursement for Dental Services

The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage, The Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:
UnitedHealthcare Dental
ATTN: Claims Unit
P. O. Box 30567
Salt Lake City, UT 84130-0567

If the Insured Person would like to use a claim form, call Customer Service at the number listed on the Insured's Dental ID Card. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in the Definitions section of the Certificate of Coverage:

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Allowed Dental Amounts are the Company's contracted fee(s) for Covered Dental Services with that provider.
- For Out-of-Network Benefits, when Covered Dental Services are received from out-of-Network Dental Providers, Allowed Dental Amounts are the Usual and Customary Fees, as defined below.

Covered Dental Service - a Dental Service or Dental Procedure for which benefits are provided under this 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 Out-of-Network Benefits in that Policy Year.

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

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

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

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

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

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this 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.

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

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

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

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

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

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

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

Policy Deductible

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

What Are the Benefit Descriptions?

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Frequency of Service Limits

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

Routine Vision Examination

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

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

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

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

Eyeglass Lenses

Lenses that are placed in eyeglass frames and worn on the face to correct visual acuity limitations.

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

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

Eyeglass Frames

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

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

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

Contact Lenses

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

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

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

Necessary Contact Lenses

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

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

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

Low Vision

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

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	50% of the billed charge.
• Bifocal		100% after a Copayment of $40.	50% of the billed charge.
• Trifocal		100% after a Copayment of $40.	50% of the billed charge.
• Lenticular		100% after a Copayment of $40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - $160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - $200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - $250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
Low Vision Care Services			
Low Vision Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low vision testing		100% of the billed charge.	75% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
• Low vision therapy		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from an out-of-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of Coverage applies to Vision Care Services provided under this endorsement, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

Reimbursement for Vision Care Services

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

- Insured Person’s itemized receipts.
- Insured Person's name.
- Insured Person's identification number from the ID card.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):
248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in Definitions section of the Certificate of Coverage:

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

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

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

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

UNITEDHEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

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

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

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

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used except under certain circumstances during a state of emergency or disaster. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.

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

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

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

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

Copayment and/or Coinsurance Amount

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

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

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

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

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

How Do Supply Limits Apply?

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

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

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

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Company at www.uhcsr.com/JWU or by calling *Customer Service* at 1-855-828-7716.

Refill Synchronization

The Company has a procedure to align the refill dates of Prescription Drug Products so that drugs that are refilled at the same frequency may be refilled concurrently. The Insured Person may access information on these procedures at www.uhcsr.com/JWU or by calling *Customer Service* at 800-767-0700.

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

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular Brand-name Prescription Drug Product.

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

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular reference product.

Designated Pharmacies

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

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

If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, benefits will be provided under the Out-of-Network Prescription Drug benefit.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, benefits will be provided under the Out-of-Network Prescription Drug benefit.

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Do Prior Authorization Requirements Apply?

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

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

If the Insured does not obtain prior authorization from the Company before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject, from time to time, to the Company's review and change. There may be certain Prescription Drug Products that require the Insured to notify the Company directly rather than the Insured's Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires prior authorization at www.uhcsr.com/JWU or by calling *Customer Service* at 1-855-828-7716.

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

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

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

Does Step Therapy Apply?

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

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

When Does the Company Limit Selection of Pharmacies?

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

Coverage Policies and Guidelines

The Company's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's total cost including, any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

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

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

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

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

Rebates and Other Payments

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

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

Definitions

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

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

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

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

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

Exceptions:

- Phases 1,2,3, or 4 clinical trials for which benefits are specifically provided for in the Policy.
- If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the Policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

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

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

Network Pharmacy means a pharmacy that has:

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

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

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

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

PPACA means Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications means the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, or Deductible) as required by applicable law under any of the following:

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

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

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

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

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

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

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

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

- Inhalers.
- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

Prescription Order or Refill means the directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

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

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

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

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

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

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

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

Additional Exclusions

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
4. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
8. General vitamins, except the following, which require a Prescription Order or Refill:
    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.
9. Certain unit dose packaging or repackagers of Prescription Drug Products.
10. 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.
11. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
12. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)

13. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
14. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.
15. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
16. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
17. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
19. For the purpose of this exclusion a “biosimilar” is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
20. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
21. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
22. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
25. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.

Right to Request an Exclusion Exception

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

Urgent Requests

If the Insured Person’s request requires immediate action and a delay could significantly increase the risk to the Insured Person’s health, or the ability to regain maximum function, call the Company as soon as possible. The Company will provide a written or electronic determination within 24 hours.

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

External Review

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

Expedited External Review

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

UNITEDHEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

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

President

It is hereby understood and agreed that the Policy to which this endorsement is attached is amended as follows:

An Insured Person under this insurance plan is eligible for Assistance and Evacuation Benefits in addition to the underlying plan coverage. The requirements to receive these benefits are as follows:

International Students are eligible to receive Assistance and Evacuation Benefits worldwide, except in their Home Country.

Domestic Students are eligible for Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program.

Assistance and Evacuation Benefits

DEFINITIONS

The following definitions apply to the Assistance and Evacuation Benefits described further below.

"Emergency Medical Event" means an event wherein an Insured Person's medical condition and situation are such that, in the opinion of the Company's affiliate or authorized vendor and the Insured Person's treating physician, the Insured Person requires urgent medical attention without which there would be a significant risk of death, or serious impairment and adequate medical treatment is not available at the Insured Person's initial medical facility.

"Home Country" means, with respect to an Insured Person, the country or territory as shown on the Insured Person's passport or the country or territory of which the Insured Person is a permanent resident.

"Host Country" means, with respect to an Insured Person, the country or territory the Insured Person is visiting or in which the Insured Person is living, which is not the Insured Person's Home Country.

"Physician Advisors" mean physicians retained by the Company's affiliate or authorized vendor for provision of consultative and advisory services to the Company's affiliate or authorized vendor, including the review and analysis of the medical care received by Insured Persons.

An Insured Person must notify the Company's affiliate or authorized vendor to obtain benefits for Medical Evacuation and Repatriation. If the Insured Person doesn't notify the Company's affiliate or authorized vendor, the Insured Person will be responsible for paying all charges and no benefits will be paid.

MEDICAL EVACUATION AND REPATRIATION BENEFITS

Emergency Medical Evacuation: If an Insured Person suffers a Sickness or Injury, experiences an Emergency Medical Event and adequate medical facilities are not available locally in the opinion of the Medical Director of the Company's affiliate or authorized vendor, the Company's affiliate or authorized vendor will provide an emergency medical evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the emergency medical evacuation.

Dispatch of Doctors/Specialists: If an Insured Person experiences an Emergency Medical Event and the Company's affiliate or authorized vendor determines that an Insured Person cannot be adequately assessed by telephone for possible medical evacuation from the initial medical facility or that the Insured Person cannot be moved and local treatment is unavailable, the Company's affiliate or authorized vendor will arrange to send an appropriate medical practitioner to the Insured Person's location when it deems it appropriate for medical management of a case. The Company will pay costs for transportation and expenses associated with dispatching a medical practitioner to an Insured Person's location, not including the costs of the medical practitioner's service.

Medical Repatriation: After an Insured Person receives initial treatment and stabilization for a Sickness or Injury, if the attending physician and the Medical Director of the Company's affiliate or authorized vendor determine that it is medically necessary, the Company's affiliate or authorized vendor will transport an Insured Person back to the Insured Person's permanent place of residence for further medical treatment or to recover. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Transportation after Stabilization: If Medical Repatriation is not required following stabilization of the Insured Person's condition and discharge from the hospital, the Company's affiliate or authorized vendor will coordinate transportation to the Insured Person's point of origin, Home Country, or Host Country. The Company will pay costs for economy transportation (or upgraded transportation to match an Insured Person's originally booked travel arrangements) to the Insured Person's original point of origin, Home Country or Host Country.

Transportation to Join a Hospitalized Insured Person: If an Insured Person who is travelling alone is or will be hospitalized for more than three (3) days due to a Sickness or Injury, the Company's affiliate or authorized vendor will coordinate round-trip airfare for a person of the Insured Person's choice to join the Insured Person. The Company will pay costs for economy class round-trip airfare for a person to join the Insured Person.

Return of Minor Children: If an Insured Person's minor child(ren) age 18 or under are present but left unattended as a result of the Insured Person's Injury or Sickness, the Company's affiliate or authorized vendor will coordinate airfare to send them back to the Insured Person's Home Country. The Company's affiliate or authorized vendor will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required as determined by the Company's affiliate or authorized vendor. The Company will pay costs for economy class one-way airfare for the minor children (or upgraded transportation to match the Insured Person's originally booked travel arrangement) and, if required, the cost of the services, transportation expenses, and accommodations of a non-medical escort to accompany the minor children back to the Insured Person's Home Country.

Repatriation of Mortal Remains: In the event of an Insured Person's death, the Company's affiliate or authorized vendor will assist in obtaining the necessary clearances for the Insured Person's cremation or the return of the Insured Person's mortal remains. The Company's affiliate or authorized vendor will coordinate the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. The Company will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence.

CONDITIONS AND LIMITATIONS

Assistance and Evacuation Benefits shall only be provided to an Insured Person after the Company's affiliate or authorized vendor receives the request (in writing or via phone) from the Insured Person or an authorized representative of the Insured Person of the need for the requested Assistance and Evacuation Benefits. In all cases, the requested Assistance and Evacuation Benefits services and payments must be arranged, authorized, verified and approved in advance by the Company's affiliate or authorized vendor.

With respect to any evacuation requested by an Insured Person, the Company's affiliate or authorized vendor reserves the right to determine, at its sole discretion, the need for and the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician Advisors and treating physicians as needed to make its determination.

In the event an Insured Person is incapacitated or deceased, his/her designated or legal representative shall have the right to act for and on behalf of the Insured Person.

The following Exclusions and Limitations apply to the Assistance and Evacuation Benefits.

In no event shall the Company be responsible for providing Assistance and Evacuation Benefits to an Insured Person in a situation arising from or in connection with any of the following:

1. Travel costs that were neither arranged nor approved in advance by the Company's affiliate or authorized vendor.
2. Taking part in military or police service operations.
3. Insured Person's failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
4. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.
5. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
7. Medical Evacuations directly or indirectly related to a natural disaster.
8. Subsequent Medical Evacuations for the same or related Sickness, Injury or Emergency Medical Event regardless of location.

Additional Assistance Services

The following assistance services will be available to an Insured Person in addition to the Assistance and Evacuation Benefits.

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: Upon an Insured Person's request, the Company's affiliate or authorized vendor will provide referrals to physicians, hospitals, dentists, and dental clinics in the area the Insured Person is traveling in order to assist the Insured Person in locating appropriate treatment and quality care.

Monitoring of Treatment: As and to the extent permissible, the Company's affiliate or authorized vendor will continually monitor the Insured Person's medical condition. Third-party medical providers may offer consultative and advisory services to the Company's affiliate or authorized vendor in relation to the Insured Person's medical condition, including review and analysis of the quality of medical care received by the Insured Person.

Facilitation of Hospital Admittance Payments: The Company's affiliate or authorized vendor will issue a financial guarantee (or wire funds) on behalf of Company up to five thousand dollars (US$5,000) to facilitate admittance to a foreign (non-US) medical facility.

Relay of Insurance and Medical Information: Upon an Insured Person's request and authorization, the Company's affiliate or authorized vendor will relay the Insured Person's insurance benefit information and/or medical records and information to a health care provider or treating physician, as appropriate and permissible, to help prevent delays or denials of medical care. The Company's affiliate or authorized vendor will also assist with hospital admission and discharge planning.

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, the Company's affiliate or authorized vendor will coordinate the transfer of the medication or vaccine to Insured Persons upon the prescribing physician's authorization, if it is legally permissible.
Updates to Family, Employer, and Home Physician: Upon an Insured Person's approval, the Company's affiliate or authorized vendor will provide periodic case updates to appropriate individuals designated by the Insured Person in order to keep them informed.

Hotel Arrangements: The Company's affiliate or authorized vendor will assist Insured Persons with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

Replacement of Corrective Lenses and Medical Devices: The Company's affiliate or authorized vendor will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, an Insured Person can contact the Company's affiliate or authorized vendor to have a pre-trip destination report sent to the Insured Person. This report draws upon an intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime,

emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. The global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: The Company's affiliate or authorized vendor will assist the Insured Person in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: The Company's affiliate or authorized vendor will make new reservations for airlines, hotels, and other travel services for an Insured Person in the event of a Sickness or Injury, to the extent that the Insured Person is entitled to receive Assistance and Evacuation Benefits.

Transfer of Funds: The Company's affiliate or authorized vendor will provide the Insured Person with an emergency cash advance subject to the Company's affiliate or authorized vendor first securing funds from the Insured Person (via a credit card) or his/her family.

Legal Referrals: Should an Insured Person require legal assistance, the Company's affiliate or authorized vendor will direct the Insured Person to a duly licensed attorney in or around the area where the Insured Person is located.

Language Services: The Company's affiliate or authorized vendor will provide immediate interpretation assistance to an Insured Person in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, the Company's affiliate or authorized vendor will provide the Insured Person with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

Message Transmittals: Insured Persons may send and receive emergency messages toll-free, 24-hours a day, through the Company's affiliate or authorized vendor.

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

Assistance and Evacuation Services are available 24 hours a day, 7 days a week, 365 days a year.

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at www.uhcsr.com/MyAccount and select My Benefits/Additional Benefits/UHC Global Emergency Services.
When calling the Emergency Response Center, the caller should be prepared to provide the following information:

- Caller's name, telephone and (if possible) fax number, and relationship to the Insured Person.
- Insured Person's name, age, sex, and ID Number as listed on the Insured Person's Medical ID card.
- Description of the Insured Person's condition.
- Name, location, and telephone number of hospital, if applicable.
- Name and telephone number of the attending physician.
- Information on where the physician can be immediately reached.

If the condition is a medical emergency, the Insured Person should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to the Company for consideration at the address located in the "How to File a Claim for Injury and Sickness Benefits" section of the Certificate of Coverage and are subject to all Policy benefits, provisions, limitations, and exclusions.

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

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

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Phone: Toll-free **1-800-368-1019, 800-537-7697** (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

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

Cherokee
ᏕᏛᏂᏲᏍᏗ ᎤᎾᏓᏅᏖᏗ ᎤᎾᏓᏡᎬ ᏂᏲ ᎡᏣᏠᏱᎢᏍᏓᏁᏩᎢ ᏂᏓᎬᏩᏠᎾ ᎠᏍᏯᎢ. ᎰᏩᏯ ᎠᏂ ᏇᏏᏔᏠᎦ 1-866-260-2723.

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

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla h<u>o</u> chi apela hinla. I paya 1-866-260-2723.

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

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

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

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

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

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

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

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

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

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

Ibo
Enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen
ကိုဒ်တၢ်မၤစၢၤအကိၢ်နမၤန့ၢ်အီၤသ့ဖဲလၢတလိၣ်ဟ့ၣ်အပှ့ၤဘၣ်(ခီလီ)နၣ်လီၤ. ဝံသးစူၤဆဲးကျိးဘၣ်1-866-260-2723တက့ၢ်.

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

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

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

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

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

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

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

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cɔl 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde
E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

Swahili
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
ܚܕܡܬ̈ܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܬܝܗܒܢܐ، ܐܝܬ ܩܕܡܘܟ ܡܓܢܐܝܬ. ܩܪܝܒܘܢ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

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

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

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2733

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

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

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

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

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

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

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

Yoruba
Isẹ̀ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.

POLICY NUMBER: 2023-608-11

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

NOC3 - 08/15/2023
NOC3 8-15-2023
Policy: NA

Certificate: NA

Summary Brochure: Changed "Medical Leave of Absence Eligibility requirements" paragraph.
From: A student can enroll in the student health insurance plan while on an approved medical leave of absence for a maximum of one semester if the student was enrolled in the student health insurance plan in the prior semester. In addition, if a student suffers an accident or sickness while meeting the eligibility requirements, that results in the student taking a medical leave of absence, coverage will remain in place until the end of the semester for which coverage was purchased. The student must have their medical leave of absence approved in writing by the Director of the Student Health Center or their designee to be eligible. At the time of taking the leave, the student must intend to return to Johnson & Wales University and remain a degree-seeking candidate.

To:
A student can enroll in the student health insurance plan while on an approved medical leave of absence for a maximum of one semester if the student was enrolled as an Insured under the student health insurance plan in the prior semester. In addition, if an Insured suffers an Injury or Sickness while meeting the eligibility requirements, that results in the Insured taking a medical leave of absence, coverage will remain in force until the end of the semester for which coverage was purchased. The Insured must have their medical leave of absence approved in writing by the director of the student health center (or similar position, irrespective of the title) or their designee to be eligible. At the time of taking the leave, the Insured must intend to return to Johnson & Wales University and remain a degree-seeking candidate.

NOC2 - 08/10/2023
Bid Policy:
N/A

Certificate:
N/A

Summary Brochure:

1. Removed the following wording –

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

premium.

2. Updated rates per below –

Annual: $2,668.00
Fall and Spring: $1,334.00
Summer 1: $668.00
Summer 2: $443.00
Summer 3: $225.00

NOC1 - 08/04/2023
NOC1 8/4/2023
Policy: NA

Certificate:
Changed Eligibility
From: All undergraduate day students, both domestic and international, all international graduate students, and any graduate student required to be enrolled under programmatic requirements (e.g., students enrolled in the Physician Assistant Program, on-campus Occupational Therapy Program, Addiction Counseling or Clinical Mental Health Counseling master's degree programs, etc.), registered and attending Johnson & Wales University and taking 12 credit hours (excluding full-time Johnson & Wales University employees) are eligible and enrolled in the plan on a hard waiver basis. Whether a student is “registered” and “attending” shall be determined exclusively by Johnson & Wales University.
To:
All undergraduate day students, both domestic and international, all international graduate students, and any graduate student required to be enrolled under programmatic requirements (e.g., students enrolled in the Physician Assistant Program, on-campus Occupational Therapy Program, Addiction Counseling or Clinical Mental Health Counseling master's degree programs, etc.), registered and attending Johnson & Wales University and taking credit hours (excluding full-time Johnson & Wales University employees) are eligible and enrolled in the plan on a hard waiver basis. Whether a student is “registered” and “attending” shall be determined exclusively by Johnson & Wales University.

Summary Brochure:
Added below to the “Who is eligible to enroll?” Section
Except as otherwise provided herein, the student (Named Insured, as defined in this Certificate) must actively attend classes for at least 31 days after university classes start to remain eligible. If a Named Insured ceases to be eligible within the first 31 days from the start of classes, coverage will be terminated back to the effective date for which coverage is purchased.

Home study, correspondence, and online courses do not fulfill the eligibility requirements. Notwithstanding anything herein, eligibility requirements of students enrolled in the university’s in-person programs shall not be impaired based solely on attendance of classes through an online, remote, or virtual learning environment (1) in the case of a declared federal or state public health emergency that would require online, remote, or virtual learning, or (2) in the case of attendance via online, remote, or virtual learning due to an accommodation for a disability granted by the university.

Updated Rate Table as listed below:
Spring to $1,688
Summer 3 to $246
Added 100% Allowed Amount to Mental Illness OP Visit