This Plan is Underwritten by UNITEDHEALTHCARE INSURANCE COMPANY

2015-2016

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

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THIS CERTIFICATE IS SUBJECT TO THE LAWS OF THE STATE OF NEW JERSEY.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-505-4160 or visiting us at www.firststudent.com.

Eligibility

All full time domestic and Non F1, J1 Rutgers Visa Sponsored students taking at least: 12 credits for Undergraduate, 9 credits for Graduate, and ALL F1, J1 Rutgers Visa sponsored students are automatically enrolled in this insurance Plan and the premium is added to their tuition billing, unless proof of comparable coverage is furnished.

Visiting Scholars, EOF, PALS and Early Start Programs are required to purchase this insurance Plan, unless proof of comparable coverage is furnished.

Ph. D and Ed.D students taking only research credits and Part-Time considered Full-Time by the student's department are eligible to enroll in this insurance Plan.

Online only degree programs and non-matriculated students registered for online courses only, do not fulfill the eligibility requirements.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study and correspondence do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium contribution amounts.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse, Civil Union partner, or Domestic Partner and dependent children, including any child for which the Named Insured is under court order to provide coverage, up to 26 years of age. Dependent coverage may continue after age 26 under specific circumstances. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 2015. The individual student's coverage becomes effective on the first day of the period for which premium contributions are paid or the date the enrollment form and full premium contributions are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 14, 2016. Coverage terminates on that date or at the end of the period through which premium contributions are paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Totally Disabled 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 12 months after the Termination Date.

However, if an Insured is pregnant on the Termination Date and the conception occurred while covered under the policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.

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.

Pre-Admission Notification

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

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

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

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

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

Preferred Provider Information

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

UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-4160 and/or by asking the provider when making an appointment for services.

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

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

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-800-505-4160 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

Eligible outpatient Hospital expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits up to any limits specified in the Schedule of Benefits.

Professional & Other Expenses

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

Schedule of Medical Expense Benefits

Metallic Level - Platinum
Injury and Sickness Benefits

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

Deductible Preferred Providers	**$100 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network	**$500 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Providers	**90% except as noted below**
Coinsurance Out-of-Network	**60% except as noted below**
Out-of-Pocket Maximum Preferred Providers	**$2,500 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Providers	**$5,000 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$10,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$20,000 (For all Insureds in a Family, Per Policy Year)**

The Preferred Provider Deductible or Coinsurance will not apply to any Preventive Care benefits provided under the policy.

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Policy includes both a Preferred Provider Coinsurance amount and a Preferred Provider Copayment amount, then the Preferred Provider Coinsurance amount will not be applied to those benefits that include a Preferred Provider Copayment amount. If the Policy includes both a Preferred Provider Coinsurance amount and a Preferred Provider Copayment amount, then the Preferred Provider Copayment amount will not be applied to those benefits that include a Preferred Provider Coinsurance amount. If the Covered Medical Expense is incurred for Emergency services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. Covered Medical Expense incurred for services provided by an Out-of-Network Provider during a Hospital Confinement at a Preferred Provider Hospital will be paid at the Preferred Provider Copayment, Deductible, and/or Coinsurance level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Usual and Customary Charges are based on data provided by FAIR Health, Inc. using the 90th percentile based on location of provider.

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

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

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% when treatment is rendered at the Student Health Center for the following services: services listed on the approved fee schedule on file with the Student Health Center.

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 unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider	Out-of-Network
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges

Inpatient	Preferred Provider	Out-of-Network
Routine Newborn Care See Benefits for Postpartum Care and Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	100% of Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Payable within 7 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	100% of Preferred Allowance $25 Copay per visit	Usual and Customary Charges
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Audiology and Speech Language Pathology and Benefits for Treatment of Autism or Other Developmental Disabilities.	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.	Preferred Allowance	90% of Usual and Customary Charges (The Insured's total out-of-pocket will not exceed the amount the Insured would have paid to a Preferred Provider.)
Diagnostic X-Ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.	UnitedHealthcare Pharmacy (UHCP) $15 Copay per prescription for Tier 1 $30 Copay per prescription for Tier 2 $50 Copay per prescription for Tier 3 up to a 31 day supply per prescription 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 that applies to a 31 day supply per prescription.	Usual and Customary Charges

Other	Preferred Provider	Out-of-Network
Ambulance Services	Preferred Allowance	90% of Usual and Customary Charges
Durable Medical Equipment See also Benefits for Orthotic and Prosthetic Appliances	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees	100% of Preferred Allowance $25 Copay per visit	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth and for surgical removal of bony, impacted teeth only.	90% of Usual and Customary Charges	90% of Usual and Customary Charges
Mental Illness Treatment See also Benefits for Biologically Based Mental Illness	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See also Benefits for Treatment of Alcoholism	Paid as any other Sickness	Paid as any other Sickness
Maternity See Benefits for Postpartum Care and Routine Newborn Care	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	Preferred Allowance	Usual and Customary Charges
Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes Treatment	Paid as any other Sickness	Paid as any other Sickness
Home Health Care See Benefits for Home Health Care	Paid as any other Injury or Sickness	Paid as any other Injury or Sickness
Hospice Care	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	Preferred Allowance	Usual and Customary Charges

Other	Preferred Provider	Out-of-Network
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Acupuncture in Lieu of Anesthesia	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies	Preferred Allowance	Usual and Customary Charges
Sexual Reassignment Surgery Cosmetic surgery, procedures and drugs are not covered even if related to sexual reassignment.	Paid as any other Sickness	Paid as any other Sickness

Refer to Certificate pages 17 to 24 for the following Mandated Benefits

Benefits for Treatment of Alcoholism
Benefits for Biologically Based Mental Illness
Benefits for Diabetes Treatment
Benefits for Treatment of Inherited Metabolic Disease
Benefits for Inpatient Coverage for Mastectomies
Benefits for Reconstructive Breast Surgery
Benefits for Mammography
Benefits for Prostate Cancer Testing (PSA)
Benefits for Colorectal Cancer Screening
Benefits for Treatment of Wilm's Tumor
Benefits for Audiology and Speech Language Pathology
Benefits for Pap Smear
Benefits for Wellness Health Examinations and Counseling
Benefits for Home Health Care
Benefits for Anesthesia and Hospitalization for Dental Services
Benefits for Infertility Treatment
Benefits for Orthotic and Prosthetic Appliances
Benefits for Hearing Aids
Benefits for Prescription Female Contraceptives
Benefits for Non-Standard Infant Formulas
Benefits for Lead Poisoning Screening, Newborn Hearing Loss and Childhood Immunizations
Benefits for Postpartum Care and Routine Newborn Care
Benefits for Treatment of Autism and Other Developmental Disabilities
Benefits for Oral Chemotherapy Drugs
Benefits for Treatment of Sickle Cell Anemia
Benefits for Prescription Eye Drops

UnitedHealthcare Pharmacy Benefits

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

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

$15 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

$30 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$50 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

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

Specialty Prescription Drugs – if you require Specialty Prescription Drugs, we may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Specialty Pharmacy, you will be responsible for the entire cost of the Prescription Drug. 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 that applies will reflect the number of days dispensed.

Designated Specialty Pharmacies – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Specialty Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

Please present your ID card to the network pharmacy when the prescription is filled.

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.firststudent.com and log in to your online account or call 1-855-828-7716.

When prescriptions are filled at pharmacies outside the network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

Additional Exclusions:

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as specifically provided in Benefits for Treatment of Inherited Metabolic Disease and Benefits for Non-Standard Infant Formula.

Definitions:

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

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

Designated Specialty Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Specialty Pharmacy.

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

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

Exceptions:

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

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

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

Generic means a Prescription Drug Product: that is Chemically Equivalent to a Brand-name drug.

Network Pharmacy means a pharmacy that has:

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

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

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

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

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

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

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

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

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

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

Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

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

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

3. **Hospital Miscellaneous Expenses.**
When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.
Benefits will be paid for services and supplies such as:
- The cost of the operating room.
- Laboratory tests.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**
See Benefits for Postpartum Care and Routine Newborn Care in the Mandated Benefits section.

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

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

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

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

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

9. **Physician's Visits (Inpatient).**
Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

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

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

Outpatient

11. **Surgery (Outpatient).**
Physician's fees for outpatient surgery. When these services are performed in a Physician's office, benefits are payable under Physician's Visits (Outpatient).

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

13. **Assistant Surgeon Fees (Outpatient).**
Assistant Surgeon Fees in connection with outpatient surgery.

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

15. **Physician's Visits (Outpatient).**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to 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 (Outpatient).**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    - Physical therapy.
    - Occupational therapy.
    - Cardiac rehabilitation therapy.
    - Manipulative treatment.
    - Speech therapy.

    See also Benefits for Audiology and Speech Language Pathology and Benefits for Treatment of Autism or Other Developmental Disabilities in the Mandated Benefits section.

17. **Medical Emergency Expenses (Outpatient).**
Including urgent care services and only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.

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

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

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

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

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

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

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

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

23. **Chemotherapy (Outpatient).**
See Schedule of Benefits.

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

Other

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

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

For the purposes of this benefit, the following are considered durable medical equipment:
- Braces that stabilize an injured body part and braces to treat curvature of the spine.

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

See also Benefits for Orthotic and Prosthetic Appliances in the Mandated Benefits section.

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

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

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

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

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

See also Benefits for Biologically Based Mental Illness in the Mandated Benefits section.

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

See also Benefits for Treatment of Alcoholism in the Mandated Benefits section.

31. **Maternity.**
Same as any other Sickness. See Benefits for Postpartum Care and Routine Newborn Care in the Mandated Benefits section.

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 in the Mandated Benefits section.

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

36. **Home Health Care.**
See Benefits for Home Health Care in the Mandated Benefits section.

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 14 days 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 14 days following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

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

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

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

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

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

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

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

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

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

44. **Acupuncture in Lieu of Anesthesia.**
See Schedule of Benefits

45. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

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

Maternity Testing

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

Initial screening at first visit:

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

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

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

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

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

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered, except folic acid supplements with a written prescription. For additional information regarding Maternity Testing, please call the Company at 1-800-505-4160.

Mandated Benefits

BENEFITS FOR TREATMENT OF ALCOHOLISM

Benefits will be paid the same as any other Sickness for the treatment of Alcoholism when such treatment is prescribed by a Physician.

Outpatient treatment for alcoholism shall be paid to the same extent as inpatient treatment if it is provided: 1) at a Hospital or as aftercare at a detoxification facility; 2) by an alcoholism counselor certified by the State of New Jersey; and 3) under a program approved by the New Jersey Division of Alcoholism.

Only with respect to the Alcoholism Benefit, "Hospital" shall include 1) detoxification facilities licensed pursuant to P.L. 1975, C.305 of the laws of New Jersey; and 2) licensed, certified or state approved residential treatment facilities, when the Insured Person is under a program which meets the minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation.

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

BENEFITS FOR BIOLOGICALLY BASED MENTAL ILLNESS

Benefits will be paid the same as any other Sickness for Biologically-Based Mental Illness.

“Biologically-based mental illness” means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

Benefits will not be denied for services or supplies that are Medically Necessary for the treatment of Insureds with Biologically Based Mental Illness, so long as such services or supplies are not experimental or investigational including but not limited to exclusions for:

1. Treatment of chronic conditions;
2. Physical, speech and occupational therapy that is non-restorative (does not restore previously possessed function, skill or ability);
3. Services rendered after a fixed period of time has elapsed from an Injury, procedure or the onset of Sickness;
4. Treatment of developmental disorders or developmental delay;
5. Therapy on a long-term basis;
6. Treatment of behavioral problems; and
7. Treatment of learning disabilities.

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

BENEFITS FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of diabetes if recommended or prescribed by a Physician or nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Benefits shall also include self-management education to ensure that an Insured Person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet.

Benefits provided for self-management education and education relating to diet shall be limited to visits Medically Necessary upon the diagnosis of diabetes; upon diagnosis by a Physician or nurse practitioner/clinical nurse specialist of a significant change in the Insured's symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a Physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

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

BENEFITS FOR TREATMENT OF INHERITED METABOLIC DISEASE

Benefits will be paid the same as any other Sickness for Covered Medical Expenses incurred in the therapeutic treatment of Inherited Metabolic Diseases, including the purchase of Medical Foods and Low Protein Modified Food Products, when diagnosed and determined to be a Medical Necessity by the Physician.

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated pursuant to P.L. 1977, c. 321 (c. 26:2-110 et seq.).

"Low Protein Modified Food Product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein.

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a Physician.

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

BENEFITS FOR INPATIENT COVERAGE FOR MASTECTOMIES

Benefits will be paid the same as any other Sickness for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy.

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness following a mastectomy on one breast or both breasts for reconstructive breast surgery and surgery to restore and achieve symmetry between the two breasts including the cost of prosthesis. The costs of outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer shall be included as a part of the outpatient x-ray or radiation therapy coverage.

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 a mammogram according to the following guidelines:

1. One baseline mammogram for women who are at least thirty-five but less than forty years of age;
2. One mammogram every year, or more frequently if recommended by a Physician, for women age forty and over.
3. In the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age intervals as deemed Medically Necessary by the woman's Physician.

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

BENEFITS FOR PROSTATE CANCER TESTING (PSA)

Benefits will be paid the same as any other Sickness for an annual medically recognized diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen (PSA) test for men age 50 and over who are asymptomatic and for age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

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 at regular intervals for Insured Persons age 50 and over and for Insured Persons of any age who are considered to be at high risk for colorectal cancer.

"High risk for colorectal cancer" means a person has:

1. family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
2. chronic inflammatory bowel disease; or
3. a background, ethnicity or lifestyle that the Physician believes puts the person at elevated risk for colorectal cancer.

The methods of screening for which benefits shall be provided shall include:

1. a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or
2. the most reliable, medically recognized screening test available.

The method and frequency of screening to be utilized shall be in accordance with the most recent published guidelines of the American Cancer Society and as determined Medically Necessary by the Insured Person's Physician, in consultation with the Insured Person.

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

BENEFITS FOR TREATMENT OF WILM'S TUMOR

Benefits will be paid the same as any other Sickness for the treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful, notwithstanding that any such treatment may be deemed experimental or investigational.

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

BENEFITS FOR AUDIOLOGY AND SPEECH LANGUAGE PATHOLOGY

Benefits will be paid the same as any other Sickness for Audiology and Speech Language Pathology when such services are determined by a Physician to be Medically Necessary and are performed or rendered to the Insured by a licensed audiologist or speech language pathologist.

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

BENEFITS FOR PAP SMEAR

Benefits will be paid the same as any other Sickness for an annual Pap Smear or a Pap Smear done more frequently than annually if recommended by a Physician. The benefit shall include an initial Pap Smear and any confirmatory test when Medically Necessary and are ordered by the Covered Person's Physician and includes all laboratory cost associated with the initial Pap Smear and any such confirmatory test.

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

BENEFITS FOR WELLNESS HEALTH EXAMINATIONS AND COUNSELING

Benefits will be paid the same as any other Sickness for each Insured Person for Covered Medical Expenses incurred in a health promotion program through Wellness Examinations and Counseling in which the program shall include, but not be limited to, the following tests and services:

1. For all Insured Persons 20 years of age or older:
   a. Annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level; or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level; and
   b. Annual consultation with a Physician to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.
2. For all Insured Persons 35 years of age or older, a glaucoma eye test every five years.
3. For all Insured Persons 40 years of age or older, an annual stool examination for presence of blood.
4. For all Insured Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years.
5. For all insured women 20 years of age or older, a pap smear as set forth in the Benefits for Pap Smear.
6. For all insured women 40 years of age or older, a mammogram as set forth in the Benefits for Mammography.
7. For all insured adults, recommended immunizations.

If a Physician or other health care provider recommends that it is Medically Necessary to receive a different schedule of tests and services other than those specified above, benefits for these tests and services shall be paid the same as any other Sickness.

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

BENEFITS FOR HOME HEALTH CARE

Benefits will be paid the same as any other Sickness for Home Health Care as hereinafter defined.

"Home Health Care" means those nursing and other home health care services rendered to an Insured who is the patient in his place of residence, under all the following conditions:

1. On a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than 3 days) basis.
2. If continuing Hospitalization would otherwise have been required if home health care were not provided.
3. Pursuant to a Physician's written order and under a plan of care established by the responsible Physician working with a Home Health Care Provider. The Physician must review the plan monthly and certify monthly that continued confinement in a Hospital would otherwise be required. That Physician may not be related to the Home Health Care Provider by ownership or contract. All care plans shall be established within 14 days following commencement of home health care.
4. Home health care services will include benefits for hemophilia, including expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of State approved hemophilia treatment center. These benefits shall be provided to the same extent as any other Sickness under the Policy. “Blood product” includes, but is not limited to Factor VIII, Factor IX and, cryoprecipitate. “Blood infusion equipment” includes, but is not limited to, syringes and needles.

"Home Health Care Provider" means a home health care agency which is certified to participate as a home health agency under Title XVIII of the Social Security Act or licensed by the New Jersey Department of Health and Senior Services as a home health agency.

"Home Health Care Services" means any of the following services which are Medically Necessary to achieve the plan of care referred to in condition (3) above and are provided for the care of the Insured Person: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this policy if the Insured were in a Hospital; and any diagnostic or therapeutic service, including surgical services performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, to the extent such service would be covered by this policy if performed as an inpatient Hospital service, provided that service is performed as part of the plan of care.

LIMITATIONS - Home Health Care Benefits are subject to the following limitations:

1. Services must follow a Hospital Confinement of at least 3 consecutive days. Services must begin not more than 3 days after the end of that confinement.
2. Any visit by a member of a home health care team on any day will be considered one home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months.
3. The amount payable for a home health care visit shall not exceed for each of the first three days on which services are provided the daily room and board benefit provided by this policy during the prior confinement; for each subsequent day of such services, the amount payable shall not exceed one-half of the daily room and board benefit provided by this policy during the prior confinement.

The services and supplies must be furnished and charged for by a Home Health Care Provider.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL SERVICES

Benefits will be paid the same as any other Sickness for an Insured who is severely disabled or a child age five or under for Covered Medical Expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the Policy which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

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

BENEFITS FOR INFERTILITY TREATMENT

Benefits will be paid the same as any other Sickness for Medically Necessary expenses incurred in the diagnosis and treatment of infertility for an Insured Person. Benefits include but are not limited to the following services related to Infertility: diagnosis and diagnostic tests; medications; surgery; in vitro fertilization; embryo transfer; artificial insemination; gamete intra fallopian transfer; zygote intra fallopian transfer; intracytoplasmic sperm injection; and four completed egg retrievals per lifetime of the Insured Person (excluding egg retrievals at the person's own expense.)

In vitro fertilization, gamete intra fallopian transfer and zygote intra fallopian transfer shall be limited to an Insured Person who: (a) has used all reasonable, less expensive and medically appropriate treatments and is still unable to become pregnant or carry a pregnancy; (b) has not reached the limit of four complete egg retrievals; and (c) is 45 years of age or younger.

Infertility means the disease or condition that results in the abnormal function of the reproductive system such that a person is not able to: impregnate another person; conceive after two years of unprotected intercourse if the female partner is under 35 years of age, or one year of unprotected intercourse if the female partner is 35 years of age or older or one of the partners is considered medically sterile; or carry a pregnancy to live birth.

The benefits shall be provided to the same extent as for other pregnancy-related procedures under the Policy, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

Benefits payable for medications, including injectible infertility medications, will not be subject to any Policy exclusions for Prescription Drugs or injections.

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

BENEFITS FOR ORTHOTIC AND PROSTHETIC APPLIANCES

Benefits will be paid based on the Medicare allowance amount for Orthotic and Prosthetic appliances when such appliances are determined by a Physician to be Medically Necessary and are obtained by the Insured from a licensed orthotist or prosthetist or a certified pedorthist.

"Orthotic appliance" means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

"Prosthetic appliance" means any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs, or other devices which should not by their use have a significantly detrimental impact upon the muscular skeletal functions of the body.

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 the same as any other Sickness for Medically Necessary Covered Medical Expenses incurred for the purchase of a hearing aid for an Insured Person 15 years of age or younger. Benefits include one hearing aid for each ear when prescribed or recommended by a licensed Physician or audiologist.

Benefits are limited to one hearing aid per each hearing-impaired ear during a 24 month period.

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

BENEFITS FOR PRESCRIPTION FEMALE CONTRACEPTIVES

Benefits will be paid the same as any other Prescription Drug for Prescription Female Contraceptives.

"Prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a Physician licensed and authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms.

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

BENEFITS FOR NON-STANDARD INFANT FORMULAS

Benefits will be paid the same as any other Prescription Drugs for the purchase of specialized non-standard infant formulas, when the insured infant's Physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be Medically Necessary, and when the insured infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. This benefit may be subject to utilization review, including periodic review, of the continued Medical Necessity of the specialized infant formula.

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

BENEFITS FOR LEAD POISONING, NEWBORN HEARING LOSS AND CHILDHOOD IMMUNIZATIONS

Benefits will be paid the same as any other Sickness, except that no Deductible will be applied, for the following services:

1. Screening by blood lead measurement for lead poisoning for eligible Dependent Children, including confirmatory blood testing as specified by the New Jersey Department of Health and Senior Services and including medical evaluation and any necessary medical follow-up or treatment for lead poisoned eligible Dependent Children.
2. Screening for Newborn Hearing Loss by appropriate electrophysiologic screening measures and periodic monitoring of eligible Dependent Infants for delayed onset hearing loss.
3. All childhood Immunizations as recommended by the Advisory on Immunization Practices of the United States Public Health Service and the New Jersey Department of Health and Senior Services.

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

BENEFITS FOR POSTPARTUM CARE AND ROUTINE NEWBORN CARE

Benefits will be paid the same as any other Sickness for expenses incurred for a mother and her newly born child in a Hospital for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section.

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

BENEFITS FOR TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES

Benefits will be paid the same as any other Sickness for screening and diagnosing autism or another developmental disability. When an Insured Person's primary diagnosis is autism or another developmental disability, the Company will provide benefits for Covered Medical Expenses incurred for Medically Necessary occupational therapy, physical therapy, and speech therapy, up to the number of days prescribed in the treatment plan by the Insured Person's Physician. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

Any visit limits in the policy for physical, occupational, and speech therapy shall be applied separately from physical, occupational, and speech therapy provided for the treatment of autism.

"Developmental disability" means a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or combination of mental or physical impairments; (2) is manifested before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more functional areas of life activity: self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living or economic self-sufficiency; and (5) reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida, and other neurological impairments where the above criteria are met.

When the Insured Person's primary diagnosis is autism and the Insured Person is under age 21, the Company will provide coverage for Covered Medical Expenses incurred for Medically Necessary behavioral interventions. The interventions should be based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed in the treatment plan by the Insured Person's Physician.

Benefits shall also include any Covered Medical Expenses incurred by the Insured Person under an individualized family service plan through a family cost share.

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

BENEFITS FOR ORAL CHEMOTHERAPY DRUGS

Benefits will be paid the same as any other Prescription Drug for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the policy; provided that the Copayment, Coinsurance, and Deductibles are at least as favorable to an Insured Person as the Copays, Coinsurance or Deductibles that apply to intravenous or injected anticancer medications.

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

BENEFITS FOR TREATMENT OF SICKLE CELL ANEMIA

Benefits will be paid the same as any other Sickness for Medically Necessary Covered Medical Expenses incurred for the treatment of sickle cell anemia.

Benefits will be paid the same as any other Prescription Drug for medications prescribed for the treatment of sickle cell anemia.

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

BENEFITS FOR PRESCRIPTION EYE DROPS

Benefits will be paid the same as any other Prescription Drug for Covered medical Expenses incurred for refills of prescription eye drops in accordance with the Guidance for Early Refill Edits of Topical Ophthalmic Products provided that:

1. The prescribing Physician indicates on the original prescription that additional quantities of the prescription eye drops are needed.
2. The requested refill does not exceed the number of additional quantities indicated on the original prescription.

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

Coordination of Benefits and Services

PURPOSE OF THIS PROVISION

An Insured may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this Policy as a Student and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows the Company to coordinate what the Company pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured is covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

(1) **Allowable Expense:** The charge for any health care service, supply or other item of expense for which the Insured is liable when the health care service, supply or other item of expense is covered at least in part by any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense. The Company will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is a Medical Necessity. When this Policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Company will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

(2) **Claim Determination Period:** A Policy Year, or portion of a Policy Year, during which an Insured is covered by this Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

(3) **Plan:** Coverage with which coordination of benefits is allowed. Plan includes:

a) group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law; b) self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law; c) group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law; d) group hospital indemnity benefit amounts that exceed $150 per day; e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or nongovernmental plan.

Plan does not include:

a) individual or family insurance contracts or subscriber contracts; b) individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans; c) group or group-type coverage where the cost of coverage is paid solely by the Insured except when coverage is being continued pursuant to a Federal or State continuation law; d) group hospital indemnity benefit amounts of $150 per day or less; e) school accident-type coverage; f) a State plan under Medicaid.

(4) **Primary Plan:** The Plan whose benefits for an Insured's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
b) All Plans which cover the Insured use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

(5) **Reasonable and Customary:** An amount that is not more than the usual or customary charge for the service or supply as determined by the Company, based on a standard which is most often charged for a given service by a provider within the same geographic area.

(6) **Secondary Plan:** The Plan which is not a Primary Plan. If an Insured is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple secondary plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary And Secondary Plan

The Company considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. The Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the Procedures to be Followed by the Secondary Plan to Calculate Benefits section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically Necessary and appropriate services and supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

(1) The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Insured as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

(2) The benefits of the Plan that covers the Insured as an employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers the Insured as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

(3) The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Insured under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

(4) If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

   a) The benefits of the Plan of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
   b) If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
   c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
   d) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

(5) If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

   a) The benefits of the Plan of the parent with custody of the child will pay first;
   b) The benefits of the Plan of the spouse of the parent with the custody of the child will pay second; and
   c) The benefits of the Plan of the parent without custody of the child will pay last.
   d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

(1) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
(2) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the Insured may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Insured uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the health maintenance organization (HMO) pays the provider a fixed amount per Insured. The Insured is liable only for the applicable deductible, coinsurance or copayment. If the Insured uses the services of a non-network provider, the HMO will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The secondary plan shall pay the lesser of:

1) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

1) the difference between the amount of the billed charges for the Allowable Charges and the amount paid by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Insured shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Insured has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the Insured be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

1) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
2) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Insured receives services or supplies from a provider who is in the network of both the Primary Plan and the secondary Plan, the Secondary Plan shall pay the lesser of:

1) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If the Insured receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Insured shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Right to Receive and Release Needed Information – Certain facts are needed to apply these Coordination of Benefits and Services rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give the Company any facts it needs to pay the claim.

Facility of Payment – A payment made under another plan may include an amount which should have been paid under this Policy. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Policy. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery – If the amount of the payments made by the Company is more than it should have paid under this provision, it may recover the excess from one or more of: a) the persons it has paid or for whom it has paid; b) insurance companies; or c) other organizations. The "amount of the payments made" includes the reasonable monetary value of any benefits provided in the form of services.

AUTOMOBILE RELATED INJURY BENEFIT PROVISION
(in association with the Coordination of Benefits provision)

Definitions

"Automobile Related Injury" means bodily injury sustained by an Insured Person as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means any Medically Necessary, reasonable, and customary item of expense, a part of which is covered by the policy or PIP at least in part as an Eligible Expense.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the policy without application of any Deductible or coinsurance, if any.

"Out-of-State Automobile Insurance Coverage (OSAIC)" means any coverage for medical expenses under an automobile insurance policy other than PIP, as PIP is defined herein, including automobile insurance policies issued in another state or jurisdiction.

"PIP" means Personal Injury Protection coverage (specifically those provisions for medical expense coverage) provided as part of an automobile insurance policy issued in the state of New Jersey.

Application of Benefits

When Covered Medical Expenses are incurred as the result of an Automobile Related Injury, and the injured Insured Person has coverage under PIP or OSAIC, the following sections will be used to determine whether the policy provides coverage that is primary or secondary to auto coverage. These sections will be also be used to determine the amount payable if the policy provides primary or secondary coverage.

Determination of Primary or Secondary Coverage

The policy provides secondary coverage to PIP, unless health coverage has been elected as primary coverage by or for the Insured Person covered under the policy. This election is made by the Named Insured under a PIP policy and affects the Dependents of the Named Insured who are not themselves the Named Insured under another auto policy. The policy may be primary for one covered person, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The policy is secondary to OSAIC. However, if the OSAIC contains provisions which make it secondary or excess to the Named Insured's Plan, then the Named Insured's Plan will be primary.

Effect on Benefits

If the Named Insured's Plan is primary to PIP or OSAIC, the policy will pay benefits on eligible expenses in accordance with the terms provided in the policy.

If the Named Insured's Plan is one of several insurance plans which provide benefits to the Insured and are primary to automobile insurance coverage, then the rules as provided in the Coordination of Benefits provision endorsement shall apply.

If the Named Insured's Plan is secondary to PIP or OSAIC, the benefits payable will be the lesser of: 1) the remaining uncovered allowable expenses after PIP has provided coverage after application of any Deductible or coinsurance; or 2) the actual benefits that would have been payable had the Named Insured's Plan been providing coverage primary to PIP.

To the extent that the policy provides coverage that supplements coverage under Medicare, then the Named Insured's Plan can be primary to auto insurance only insofar as Medicare is primary to auto insurance.

Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

Application must be made and premium contribution must be paid directly to UnitedHealthcare **Student**Resources and be received within 30 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare **Student**Resources.

Definitions

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

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

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium contribution, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

CIVIL UNION means the legally recognized union of two eligible individuals of the same sex established pursuant to the Civil Union Act. Parties to a civil union shall receive the same benefits and protections and are subject to the same responsibilities as spouses in marriage. Civil Union includes those same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

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

COMPLICATION OF PREGNANCY means 1) conditions requiring medical treatment prior to or subsequent to termination of pregnancy, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, acute nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) non-elective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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

COPAY/COPAYMENT means the amount that the Insured is required to pay for certain Covered Medical Expenses. A Copay/Copayment may be either a specific dollar amount or a percentage of Covered Medical Expenses.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

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

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

DEPENDENT means the legal spouse, a Civil Union partner, or Domestic Partner of the Named Insured and dependent children, including any child:

1. For which the Named Insured is under court order to provide coverage.
2. Over whom the Named Insured has legal custody, legal guardianship or a legal relationship.
3. With whom the Named Insured has a blood relationship, provided the child lives with the Named Insured and is dependent upon the Named Insured for most of his or her support and maintenance.

Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

A dependent will be eligible to continue coverage after age 26, up to the dependent's 31st birthday, if the dependent meets all of the following:

1. Resides in New Jersey; or if not a resident, is a full-time student at an accredited public or private institution of higher education.
2. Has evidence of creditable coverage or receipt of benefits under a group health plan, a church plan, an individual health benefits plan, or Medicare.
3. Is not covered under another group health plan, church plan, individual health benefits plan, and is not entitled to Medicare as of the effective date of coverage.
4. Does not have any children.
5. Does not have a spouse, Civil Union partner, or Domestic Partner.

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

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

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually after the two year period following the child's attainment of the limiting age. Termination will continue to be waived only while all of the above conditions are met and the Insured continues to be insured under this policy.

If the Named Insured's insurance under this policy terminates due to that person's death, insurance then in force on such Named Insured's Dependents will be continued for 180 days. This continuation of coverage is subject to the timely payment of the premium contribution due for the Insured Dependent's insurance and the policy provisions with respect to termination for reasons other than death of the Insured.

DOMESTIC PARTNER means a person who is not related by blood or marriage to the Named Insured but who:

1. Is, along with the Named Insured, age 62 years or older, regardless of gender;
2. Lives together with the Named Insured in the same residence and intends to do so indefinitely;
3. Is responsible with the Named Insured for each other's basic living expenses;
4. Is not in a marriage recognized by New Jersey law or a member of another domestic partnership;
5. Has chosen with the Named Insured to share each other's lives in a committed relationship of mutual caring;
6. Files with the Name Insured an Affidavit of Domestic Partnership; and
7. Has not been in a domestic partnership that was terminated less than 180 days prior to the filing of a current Affidavit of Domestic Partnership; this prohibition will not apply if the prior partner died.

A domestic partner relationship may be demonstrated by anyone of the following types of documentation: 1) a joint deed, mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, banking account or credit account.

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

EMERGENCY SERVICES means, with respect to a Medical Emergency:

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

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

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

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

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

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

INJURY means bodily injury to an Insured Person which is all of the following:

1. caused by an accident which occurs while this policy is in force as to that Insured Person.
2. treated by a Physician within 30 days after the date of accident.
3. Which, directly and independently of all other causes, results in a loss covered by the policy.

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

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

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

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium contribution has been paid. The term "Insured" also means Insured Person.

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

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

MEDICAL EMERGENCY means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention would result in any of the following:

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

With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another Hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY/MEDICALLY NECESSARY means or describes those health care services that a health care provider or facility, including but not limited to a Hospital or Physician, exercising prudent clinical judgment, would provide to an Insured Person, which are all of the following:

1. For the purpose of evaluating, diagnosing, or treating a Sickness or Injury, or its symptoms.
2. Provided in accordance with the generally accepted standards of medical practice.
3. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Insured Person's Injury or Sickness.
4. Not primarily for the convenience of the Insured Person or the Physician.
5. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Insured Person's Injury or Sickness.

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

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. Mental illness does not mean a Biologically Based Mental Illness as defined in the Benefits for Biologically Based Mental Illness. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth on the same basis as any other Dependent children. Benefits for such a child will be for Injury or Sickness and paid on the same basis as any other Injury or Sickness, including medically diagnosed congenital defects and birth abnormalities.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to us; and 2) pay the required additional premium contribution, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

OTHER VALID AND COLLECTIBLE GORUP INSURANCE means: 1) any group plan, program or insurance policy; 2) any other group hospital, surgical or medical benefit plan; 3) union welfare plans; or 4) group employer or employee benefit programs.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial Expenses will be paid at 100% for the remainder of the Policy Year. All Covered Medical Expenses paid as Copayment, Coinsurance, and Deductible shall count toward the Out-of-Pocket Maximum. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

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

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

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

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

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, including "off-label" use of Food and Drug Administration ("FDA") approved drugs, which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

Prescription Drugs also means a drug prescribed for treatment which has not been approved by the FDA, however, the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in the: 1) American Hospital Formulary Service Drug Information; 2) United States Pharmacopeia Drug Information; or is recommended by a clinical study or review article in a major peer-reviewed professional journal.

Prescription Drugs does not mean any experimental or investigational drug; or any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

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

SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition not separated by more than six months after a return to normal activity will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

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

SOUND, NATURAL TEETH means natural teeth, the major portion of which are present, regardless of fillings.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

TOTALLY DISABLED/TOTAL DISABILITY means a condition of a Named Insured which, because of Sickness or Injury, renders the Named Insured unable to actively attend classes. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

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

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

Exclusions and Limitations

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

1. Acupuncture, except as specifically provided in the policy.

2. Behavioral problems. Developmental delay or disorder or intellectual disability. Learning disabilities.

   This exclusion does not apply to benefits specifically provided in Benefits for Treatment of Autism and Other Developmental Disabilities.

3. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infants, including those continuously insured under the preceding student policy issued by this Company.

4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, 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:
   - As described under Dental Treatment in the policy.

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

6. Elective Surgery or Elective Treatment.

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

8. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, except for the removal of nail roots, and bunions.

   This exclusion does not apply to Medically Necessary open surgery of the foot or preventive foot care for Insured Persons with diabetes.

9. Hearing examinations. 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.
   - Benefits specifically provided in the policy.

10. Hirsutism. Alopecia.

11. 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.

12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.

13. Injury sustained while:
   - Participating in any intercollegiate, or professional sport, contest or competition.
   - Traveling to or from such sport, contest or competition as a participant.
   - Participating in any practice or conditioning program for such sport, contest or competition.

14. Lipectomy.

15. Participation in a riot or civil disorder. Loss to which a contributing cause was the Insured Person's commission of or attempt to commit a felony or engagement in an illegal occupation.

16. Prescription Drugs, services or supplies as follows:
   - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
   - Immunization agents, except as specifically provided in the policy. Biological sera.
   - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for a drug for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia: (1) the American Medical Association Drug Evaluations; (2) the American Hospital Formulary Service Drug Information; (3) the United States Pharmacopeia Drug Information; or it is recommended by a clinical study or review article in a major peer-reviewed professional journal. Any coverage of a drug shall also include Medically Necessary services associated with the administration of the drug.
   - Products used for cosmetic purposes, except as specifically provided in the policy.
   - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
   - Anorectics - drugs used for the purpose of weight control.
   - Sexual enhancement drugs, such as Viagra.
   - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

17. Reproductive services including but not limited to the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Female sterilization procedures, except as specifically provided in the policy.
    - Vasectomy.
    - Reversal of sterilization procedures.

    This exclusion does not apply to benefits specifically provided in Benefits for Infertility Treatment.

18. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.

19. 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 one pair of eyeglasses or contact lenses for the initial replacement for the loss of a natural lens.

20. Preventive care services, except as specifically provided in the policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.

21. Services provided normally without charge.

22. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.

23. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.

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

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

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

27. War or any act of war, declared or undeclared or while the Insured Person:
    - Is serving in the armed forces of any country.
    - Is serving in any civilian non-combatant unit supporting or accompanying any armed forces of any country or international organization.
    - Is not serving in any armed forces if the Injury or Sickness occurs outside the 50 states of the United States of America, the District of Columbia or Canada.

    A pro-rata premium contribution will be refunded upon request for such period not covered.

28. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Benefits for Treatment of Inherited Metabolic Disease.

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.firststudent.com. Insured students who don't already have an online account may simply select the ***My Account*** link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

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

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

ID Cards

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

UHCSR Mobile App

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

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

UnitedHealth Allies

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

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

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

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

3. Submit claims for payment within 90 days after the date of service. If it was not reasonably possible to give written proof in the time required, claims will not be reduced or denied for this reason. This time limit does not apply if the Insured is legally incapacitated.

Submit all Claims or Inquiries to:

FirstStudent
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-505-4160
or visit our website at www.firststudent.com

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 1-877-816-3596 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured's ID card.

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

Covered Dental Services

Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Dental Provider.

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

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, the Insured Person may receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy.

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

Pre-Authorization

Pre-authorization is required for all Dental Services and Dental Procedures. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.
If a treatment plan is not submitted, the Insured Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

Section 2: Benefits for Pediatric Dental Services

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

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

Benefits

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Benefits, benefits will be provided for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services as described in this endorsement for Insured Persons under the age of 19 when services are provided by a Dental Provider.

1. Dental services are available from birth with an age one dental visit encouraged.
2. A second opinion is allowed.
3. Dental Emergency treatment is available without prior authorization. Dental Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
4. Diagnostic and preventive services are linked to the Dental Provider, thus allowing an Insured Person to transfer to a different Dental Provider and receive these services. The new Dental Provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.

5. Denials of services to the Dental Provider shall include an explanation and identify the reviewer including their contact information.
6. Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
7. Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
8. Services that are considered Experimental, Investigational, or Unproven in nature will not be considered.
9. This endorsement will not cover any charges for broken appointments.

Diagnostic Services

* Indicates diagnostic services that can be considered every 3 months for Insureds with special healthcare needs.

1. Clinical oral evaluations once every 6 months *
   - Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
   - Periodic oral evaluation – subsequent thorough evaluation of an established insured patient*
   - Oral evaluation for an Insured under the age of 3 and counseling with primary caregiver*
   - Limited oral evaluations that are problem focused
   - Detailed oral evaluations that are problem focused
2. Diagnostic imaging with interpretation
   - A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
   - An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
   - Additional films/views needed for diagnosing can be provided as needed.
   - Bitewings, periapicals, panoramic and cephlometric radiographic images
   - Intraoral and extraoral radiographic images
   - Oral/facial photographic images
   - Maxillofacial MRI, ultrasound
   - Cone beam image capture
3. Tests and Examinations
4. Viral culture
5. Collection and preparation of saliva sample for laboratory diagnostic testing
6. Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
7. Oral pathology laboratory
   - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
   - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
   - Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for Insureds.

1. Dental prophylaxis once every 6 months*
2. Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
3. Fluoride varnish once every 3 months for Insured Dependents under the age of 6
4. Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
5. Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
   - fixed – unilateral and bilateral
   - removable – bilateral only
   - recementation of fixed space maintainer
   - removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

1. There are no frequency limits on replacing restorations (fillings) or crowns.
2. Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.
3. Reimbursement will include the restorative material and all associated materials Necessary to provide the standard of care, polishing of restoration, and local anesthesia.
4. The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
5. Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
6. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
7. Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

1. Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
2. Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
3. Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
4. Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
   - Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
   - Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
   - Provisional crowns are not covered.
5. Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
6. Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
7. Core buildup including pins
8. Pin retention
9. Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
10. Additional fabricated (custom fabricated/cast) and prefabricated post
11. Post removal
12. Temporary crown (fractured tooth)
13. Additional procedures to construct new crown under existing partial denture
14. Coping
15. Crown repair
16. Protective restoration/sedative filling

Endodontic Services

1. Service includes all Necessary radiographs or views needed for endodontic treatment.
2. Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
3. Emergency services for pain do not require prior authorization.
4. Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

1. Therapeutic pulpotomy for primary and permanent teeth
2. Pulpal debridement for primary and permanent teeth
3. Partial pulpotomy for apexogensis
4. Pulpal therapy for anterior and posterior primary teeth
5. Endodontic therapy and retreatment
6. Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
7. Apexification: initial, interim and final visits
8. Pulpal regeneration
9. Apicoectomy/Periradicular Surgery
10. Retrograde filling
11. Root amputation
12. Surgical procedure for isolation of tooth with rubber dam
13. Hemisection
14. Canal preparation and fitting of preformed dowel or post
15. Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

1. Surgical services
   - Gingivectomy and gingivoplasty
   - Gingival flap including root planning
   - Apically positioned flap
   - Clinical crown lengthening
   - Osseous surgery
   - Bone replacement graft – first site and additional sites
   - Biologic materials to aid soft and osseous tissue regeneration
   - Guided tissue regeneration
   - Surgical revision
   - Pedicle and free soft tissue graft
   - Subepithelial connective tissue graft
   - Distal or proximal wedge
   - Soft tissue allograft
   - Combined connective tissue and double pedicle graft
2. Non-Surgical Periodontal Service
   - Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
   - Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
   - Full mouth debridement to enable comprehensive evaluation
   - Localized delivery of antimicrobial agents
3. Periodontal maintenance

Prosthodontic Services

1. All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
2. New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
3. All needed dental treatment must be completed prior to denture fabrication.
4. Patient identification must be placed in dentures in accordance with State Board regulation.
5. Insertion of dentures includes adjustments for 6 months post insertion.
6. Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

1. Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
2. Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
   - Resin base and cast frame dentures including any conventional clasps, rests and teeth
   - Flexible base denture including any clasps, rests and teeth
   - Removable unilateral partial dentures or dentures without clasps are not considered
3. Overdenture – complete and partial
4. Denture adjustments –6 months after insertion or repair
5. Denture repairs – includes adjustments for first 6 months following service
6. Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
7. Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
8. Precision attachment, by report
9. Maxillofacial prosthetics - includes adjustments for first 6 months following service
   - Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
   - Obturator prosthesis: surgical, definitive and modifications
   - Mandibular resection prosthesis with and without guide flange
   - Feeding aid
   - Surgical stents
   - Radiation carrier
   - Fluoride gel carrier
   - Commissure splint
   - Surgical splint
   - Topical medicament carrier
   - Adjustments, modification and repair to a maxillofacial prosthesis
   - Maintenance and cleaning of maxillofacial prosthesis
10. Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
    Covered services include: implant body, abutment and crown.
11. Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
    - The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
    - A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
    - Considerations and requirements noted for single crowns apply
    - Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
    - Abutment teeth must be periodontally sound and have a good long term prognosis
    - Repair and recementation
12. Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

1. Extraction of teeth:
   - Extraction of coronal remnants – deciduous tooth,
   - Extraction, erupted tooth or exposed root
   - Surgical removal of erupted tooth or residual root
   - Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
2. Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
3. Other surgical Procedures
   - Oroantral fistula
   - Primary closure of sinus perforation and sinus repairs
   - Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
   - Surgical access of an unerupted tooth
   - Mobilization of erupted or malpositioned tooth to aid eruption
   - Placement of device to aid eruption
   - Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
   - Surgical repositioning of tooth/teeth
   - Transseptal fiberotomy/supra crestal fiberotomy
   - Surgical placement of anchorage device with or without flap
   - Harvesting bone for use in graft(s)
4. Alveoloplasty in conjunction or not in conjunction with extractions
5. Vestibuloplasty
6. Excision of benign and malignant tumors/lesions
7. Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
8. Destruction of lesions by electrosurgery
9. Removal of lateral exostosis, torus palatinus or torus madibularis
10. Surgical reduction of osseous tuberosity
11. Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
12. Surgical Incision
    - Incision and drainage of abcess - intraoral and extraoral
    - Removal of foreign body
    - Partial ostectomy/sequestrectomy
    - Maxillary sinusotomy
13. Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
14. Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
    - Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
    - Manipulation under anesthesia
    - Condylectomy, discectomy, synovectomy
    - Joint reconstruction
    - Services associated with TMJD treatment require prior authorization
15. Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
16. Arthroscopy
17. Occlusal orthotic device – includes placement and removal to same provider
18. Surgical and other repairs
    - Repair of traumatic wounds – small and complicated
    - Skin and bone graft and synthetic graft
    - Collection and application of autologous blood concentrate
    - Osteoplasty and osteotomy
    - LeFort I, II, III with or without bone graft
    - Graft of the mandible or maxilla – autogenous or nonautogenous

- Sinus augmentations
- Repair of maxillofacial soft and hard tissue defects
- Frenectomy and frenoplasty
- Excision of hyperplastic tissue and pericoronal gingiva
- Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
- Emergency tracheotomy
- Coronoidectomy
- Implant – mandibular augmentation purposes
- Appliance removal – "by report" for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical Necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

1. Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
2. Orthodontic consultation can be provided once annually as needed by the same provider.
3. Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
4. Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
5. Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to the Insured's 19th birthday.
6. Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
7. The placement of the appliance represents the treatment start date.
8. Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
9. Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

1. Limited treatment for the primary, transitional and adult dentition
2. Interceptive treatment for the primary and transitional dentition
3. Minor treatment to control harmful habits
4. Continuation of transfer cases or cases started outside of the program
5. Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate Medical Necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented Medical Necessity.
6. Orthognathic Surgical Cases with comprehensive orthodontic treatment
7. Repairs to orthodontic appliances
8. Replacement of lost or broken retainer
9. Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

1. Palliative treatment for emergency treatment – per visit
2. Anesthesia
   - Local anesthesia NOT in conjunction with operative or surgical procedures.
   - Regional block
   - Trigeminal division block.
   - Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
   - Intravenous conscious sedation/analgesia – 2 hour maximum time
   - Nitrous oxide/analgesia
   - Non-intravenous conscious sedation – to include oral medications
3. Behavior management – for <u>additional</u> time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
   - One unit equals 15 minutes of additional time
   - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
     - Office or Clinic maximum – 2 units
     - Inpatient/Outpatient hospital – 4 units
     - Skilled Nursing/Long Term Care – 2 units
4. Consultation by specialist or non-primary care provider
5. Professional visits
   - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
   - Hospital or ambulatory surgical center call
     - For cases that are treated in a facility.
     - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
     - General anesthesia and outpatient facility charges for dental services are covered.
     - Dental services rendered in these settings by a dentist not on staff are considered separately.
   - Office visit for observation – (during regular hours) no other service performed
6. Drugs
   - Therapeutic parenteral drug
     - Single administration
     - Two or more administrations - not to be combined with single administration
   - Other drugs and/or medicaments – by report
7. Application of desensitizing medicament – per visit
8. Occlusal guard – for treatment of bruxism, clenching or grinding
9. Athletic mouthguard covered once per year
10. Occlusal adjustment
    - Limited - (per visit)
    - Complete (regardless of the number of visits), once in a lifetime
11. Odontoplasty
12. Internal bleaching

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

Benefit Description	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses
Preventive Services	100%	50%
Diagnostic Services	100%	50%
Restorative Services	50%	50%
Endodontic Services	50%	50%
Periodontal Services	50%	50%
Prosthodontic Services	50%	50%
Oral and Maxillofacial Surgical Services	50%	50%
Orthodontic Treatment	50%	50%
Adjunctive General Services	50%	50%

Section 3: Pediatric Dental Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Any Dental Procedure not directly associated with dental disease.
6. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
7. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
8. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
9. Foreign Services are not covered unless required for a Dental Emergency.
10. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
11. Acupuncture; acupressure and other forms of alternative treatment, except acupuncture when used as a substitute for other forms of anesthesia.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

To file a claim, submit the above information to the Company at the following address:

UnitedHealthcare Dental
Attn: Claims Unit
P.O. Box 30567
Salt Lake City, UT 84130-0567

Submit claims for payment within 90 days after the date of service. If it was not reasonably possible to give written proof in the time required, claims will not be reduced or denied for this reason. This time limit does not apply if the Insured is legally incapacitated.

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery other than a member of the Insured Person's immediate family, including spouse, brother, sister, parent, or child.

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.

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

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

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

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

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

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

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

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

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

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits

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

Non-Network Benefits

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

Policy Deductible

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

Benefit Description

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

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

Comprehensive Vision Examination

A comprehensive vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, when performed by an ophthalmologist.

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

- Standard scratch-resistant coating.
- Polycarbonate lenses.

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

Contact Lenses - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts. Standard frames refer to frames that are not designer frames such as Coach, Burbury, Prada and other designers.

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

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

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

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Comprehensive Vision Exam	Once every 12 months.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses One pair of Standard Lenses.	Once every 12 months.	100% after a Copayment of $40.	50% of the billed charge.
Eyeglass Frames One pair of Standard Frames.	Once every 12 months.		
• With a retail cost up to $130.		100%.	50% of the billed charge.
• With a retail cost of $130 - 160.		100% after a Copayment of $15.	50% of the billed charge.
• With a retail cost of $160 - 200.		100% after a Copayment of $30.	50% of the billed charge.
• With a retail cost of $200 - 250.		100% after a Copayment of $50.	50% of the billed charge.
• With a retail cost greater than $250.		60%.	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
• Covered Contact Lens Selection (V2500-V2599)		100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses		100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
By facsimile (fax):
248-733-6060

Submit claims for payment within 90 days after the date of service. If it was not reasonably possible to give written proof in the time required, claims will not be reduced or denied for this reason. This time limit does not apply if the Insured is legally incapacitated.

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

Notice of Appeal Rights

RESOLUTION OF GRIEVANCE NOTICE
INTERNAL APPEAL PROCESS AND INDEPENDENT HEALTH CARE APPEAL PROCESS
RELATED TO HEALTH CARE SERVICES

INTERNAL APPEAL PROCESS

Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination, except where the Adverse Determination is based on eligibility, including rescission, or on the application of a contract exclusion or limitation not relating to Medically Necessity.

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

Within 3 working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

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

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide:

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

The new or additional information shall be provided free of charge to the Insured Person or Authorized Representative and as soon as possible and sufficiently in advance of the date on which the final Internal Review is required to be provided in order to allow the Insured Person or Authorized Representative adequate opportunity to respond to any new or additional evidence or rationale.

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

1. For a Pre-service Claim review, the notice shall be made no later than 15 days after the Company's receipt of the grievance.
2. For a Post-service Claim review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.

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

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

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

7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time. The Insured may also contact the Department of Banking and Insurance at the following address: Consumer Protection Services, Office of Managed Care, P.O. Box 329, Trenton, New Jersey 08625-0239. Phone Number (888) 393-1062.

Benefits shall continue to be provided for an ongoing course of treatment pending the outcome of the appeal.

Expedited Internal Review (EIR) of an Adverse Determination

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 Claims; and
2. related to a concurrent review Urgent Care Claim involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

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

If the EIR request is related to a concurrent review Urgent Care Claim, 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 a request for an Independent Health Care Appeal if:

1. 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. the Adverse Determination involves a denial of coverage based on the 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.

Benefits shall continue to be provided for an ongoing course of treatment pending the outcome of the appeal.

INDEPENDENT HEALTH CARE APPEAL

An Insured Person or Authorized Representative may submit a request for an Independent Health Care Appeal when the service in question:

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an Independent Health Care Appeal. The request for an Independent Health Care Appeal should be made in writing to the Commissioner on forms provided to the Insured Person at the completion of the Internal Review Process.

The request for an Independent Health Care Appeal should be accompanied by $25 filing fee, payable by check or money order to the New Jersey Department of Banking and Insurance. The fee shall be waived if a financial hardship exists. Financial hardship may be demonstrated by the Insured Person through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance. The filing fees for any one Insured Person shall not exceed $75.00 per policy year.

Benefits shall continue to be provided for an ongoing course of treatment pending the outcome of the appeal.

Independent Health Care Appeal Process

The New Jersey Department of Banking and Insurance shall forward the appeal to an IURO.

Upon receipt of the appeal, the IURO shall conduct a preliminary review and accept the request if the appeal:

a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;
b. the Insured Person has provided all the information and forms required by the IURO and the Department to make a preliminary determination; and
c. the service in question reasonably appears to be a Covered Medical Expense under the Policy.

Immediately after completion of the preliminary review, the IURO shall notify the Insured Person and, if applicable, the Authorized Representative in writing whether the request has been accepted. If the request is not complete, the IURO's notice shall include the reason(s) why the request is incomplete.

The IURO shall also notify the Insured Person and, if applicable, the Authorized Representative of the right to submit additional written information to be considered in the IURO's review. The IURO shall provide the Company with copies of any such additional information within 1 business day after receipt.

The IURO shall complete its review in a manner consistent with New Jersey state requirements. The IURO's final decisions shall be provided to the Insured Person, the Company, the Authorized Representative (if any), and the Department. The IURO's determination shall be binding on the Company and the Insured Person, except to the extent that other remedies are available under State or Federal law. The Company shall provide benefits, pursuant to and consistent with the IURO's decision, without delay, regardless of whether the Company intends to seek judicial review.

Within 10 business days of receiving the IURO's decision, the Company shall submit a report describing how the Company will implement the IURO's decision. The report shall be provided to the Insured Person, the Authorized Representative (if any), the IURO, and the Department.

Where to Send Independent Health Care Appeal Requests

All types of Independent Health Care Appeal requests shall be submitted to the New Jersey Department of Banking and Insurance.

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.

You may contact the New Jersey Department of Banking and Insurance at:

New Jersey Department of Banking and Insurance
Office of Managed Care
20 West State Street
P. O. Box 329
Trenton, NJ 08625
(800) 445-7467
(888) 393-1062 (appeals)
http://www.state.nj.us/dobi/consumer.htm
ombudsman@dobi.state.nj.us

Questions Regarding Appeal Rights

Contact Customer Service at 1-800-505-4160 with questions regarding the Insured Person's rights to an Internal Appeal and Independent Health Care Appeal.

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

This Certificate is based on Policy # 2015-519-2.