

UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

PLEASE NOTE:

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

Designed Especially for the Students of

Fairfield University

2026-2027

This Certificate of Coverage is Part of Policy # 2026-282-1

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

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

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

This policy does not provide Coverage for:

Skydiving. Hang gliding. Parasailing. Sail planing. Bungee jumping.

Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline, or chartered aircraft only while participating in a school sponsored intercollegiate sport activity.

Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:

- Recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle, four-wheeled all terrain vehicle (ATV), jet ski, ski cycle, or snowmobile.

Injury sustained while:

- Participating in any 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.

**United
Healthcare®**

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PLEASE NOTE:

The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.

Introduction

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

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

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

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

Section 1: Who Is Covered

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

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

All International Undergraduate and International Graduate students are required to purchase this insurance plan on a mandatory basis. All Full-time Domestic Undergraduate students, Graduate students, and Second Degree Nursing students are automatically enrolled in this insurance plan, unless proof of comparable coverage is provided.

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

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 2026. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 14, 2027. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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

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

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is 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 90 days after the Termination Date.

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

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

Section 4: Pre-Admission Notification

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

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

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

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

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

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

Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus

Preferred Provider Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities.

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

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

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

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

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

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

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

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

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

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

Preferred Provider Benefits

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

No Surprises Act

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

Out-of-Network Provider Benefits

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

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

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

Surprise Bill

A Surprise Bill is a bill for Covered Medical Expenses, other than Emergency Services or Urgent Care Crisis Center Services, received by an Insured for services rendered by an Out-of-Network Provider at a Preferred Provider facility during:

- A service or procedure performed by Preferred Provider.
- During a service or procedure previously approved or authorized by the Company and the Insured did not knowingly elect to obtain such services from the Out-of-Network provider, or a clinical laboratory that is an Out-of-Network provider, upon the referral of a Preferred Provider.

A Surprise Bill does not include a bill for Covered Medical Expenses received by an Insured when Preferred Provider was available to render such services and the Insured knowingly elected to obtain the services from another provider who was Out-of-Network.

If Emergency Services were rendered to an Insured by an Out-of-Network Provider, the provider may bill the Company directly and the Company shall reimburse the provider the greatest of the following amounts:

- The amount the Insured's plan would pay for the Emergency Services if rendered by a Preferred Provider.
- The Allowed Amount for such services.
- The amount Medicare would reimburse for such charges.

With respect to a Surprise Bill:

- An Insured will only be required to pay the applicable Coinsurance, Copayment, Deductible or other out-of-pocket expense that would be imposed for Covered Medical Expenses if services were rendered by a Preferred Provider.
- The Company must reimburse the Out-of-Network Provider or Insured, as applicable, for Covered Medical Expenses rendered at the Preferred Provider rate under the Insured's plan as payment in full, unless the Company and provider agree otherwise.

If Covered Medical Expenses were rendered to an Insured by an Out-of-Network Provider and the Company failed to inform the Insured, if the Insured was required to be informed, of the network status of the provider, the Company may not impose a Coinsurance, Copayment, Deductible or other out-of-pocket expense that is greater than the Coinsurance, Copayment, Deductible or other out-of-pocket expense that would be imposed if services were rendered by a Preferred Provider.

Section 6: Medical Expense Benefits

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

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

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

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

Inpatient

1. **Room and Board Expense.**
Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.
2. **Intensive Care.**
See Schedule of Benefits.

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PLEASE NOTE:

The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.

3. **Hospital Miscellaneous Expenses.**

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

Benefits will be paid for services and supplies such as:

- The cost of the operating room.
- Laboratory tests.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**

While Hospital Confined and routine nursery care provided immediately after birth.

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

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

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

See also Benefits for Postpartum Care.

5. **Surgery.**

Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**

Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**

Registered Nurse's services which are all of the following:

- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

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

9. **Physician's Visits.**

Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:

- Complete blood count.
- Urinalysis.
- Chest X-rays.

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

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

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.
12. **Day Surgery Miscellaneous.**
Facility charge and the charge for services and supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.
13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery.
14. **Anesthetist Services.**
Professional services administered in connection with outpatient surgery.
15. **Physician's Visits.**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.

Physician's Visits for preventive care are provided as specified under Preventive Care Services.
16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
 - Physical therapy.
 - Occupational therapy.
 - Cardiac rehabilitation therapy.
 - Manipulative treatment.
 - Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, Congenital Condition, or vocal nodules.
Physiotherapy provided in the Insured Person's home by a home health agency is provided as specified under Home Health Care. Physiotherapy provided in the Insured's home other than by a home health agency is provided as specified under this benefit.
17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
 - Facility charge for use of the emergency room and supplies.
All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services.**
See Schedule of Benefits. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. **Radiation Therapy.**
See Schedule of Benefits.
20. **Laboratory Procedures.**
See Schedule of Benefits. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
21. **Tests and Procedures.**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
 - Physician's Visits.
 - Physiotherapy.
 - X-rays.

- Laboratory Procedures.

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

- Inhalation therapy.
- Intravenous infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis, hemodialysis, and peritoneal dialysis.

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

22. **Injections.**

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

23. **Chemotherapy.**

See Schedule of Benefits.

24. **Prescription Drugs.**

See Schedule of Benefits.

Other

25. **Ambulance Services.**

Emergency ambulance transportation by a licensed ambulance service to a Hospital for Medical Emergency treatment.

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

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

26. **Durable Medical Equipment.**

Durable Medical Equipment must be all of the following:

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

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

- Braces that stabilize an injured body part and braces to treat curvature of the spine.

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

See also Benefits for Prosthetic Devices.

27. **Consultant Physician Fees.**

Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**

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

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

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

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

See also Benefits for Inpatient Dental Services.

29. **Gender Dysphoria Treatment.**

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

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

30. **Mental Illness Treatment.**

Benefits will be paid for services received:

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

See also Benefits for Mental or Nervous Conditions.

31. **Substance Use Disorder Treatment.**

Benefits will be paid for services received:

- On an Inpatient basis while confined to a Hospital including:
 1. Partial hospitalization/day treatment received at a Hospital.
 2. Medically monitored detoxification services; and
 3. Medically managed intensive detoxification services.
- On an outpatient basis including intensive outpatient treatment.

For the purposes of this benefit “medically monitored inpatient detoxification” and “medically managed intensive inpatient detoxification” have the same meanings as described in the most recent edition of the *American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions*.

See also Benefits for Mental or Nervous Conditions.

32. **Maternity.**

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

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

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

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

See also Benefits for Postpartum Care.

33. **Complications of Pregnancy.**

Same as any other Sickness.

34. **Preventive Care Services.**

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

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

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

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

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

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

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

This is not a comprehensive list of Preventive Care Services, and certain diagnostic services provided in relation to preventive care may require cost share. Please visit <https://www.healthcare.gov/preventive-care-benefits/> for a comprehensive list of services provided for specific age and risk groups.

35. **Reconstructive Breast Surgery Following Mastectomy.**

See Benefits for Reconstructive Breast Surgery.

36. **Diabetes Services.**

See Benefits for Diabetes and Benefits for Diabetic Outpatient Self-Management Training.

37. **High Cost Procedures.**

The following procedures provided on an outpatient basis:

- CT Scan.
- PET Scan.
- Magnetic Resonance Imaging.

38. **Home Health Care.**

See Benefits for Home Health Care.

39. **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 or hospice care program.

“Hospice care program” means a program to provide hospice services operated by an organization licensed by the Department of Public Health to provide hospice home care services.

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.

40. **Inpatient Rehabilitation Facility.**

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

41. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.
 - Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.
42. **Urgent Care Center.**
Benefits are limited to:
- Facility or clinic fee billed by the Urgent Care Center.
- All other services rendered during the visit will be paid as specified in the Schedule of Benefits.
43. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:
- Facility or clinic fee billed by the Hospital.
- All other services rendered during the visit will be paid as specified in the Schedule of Benefits.
44. **Approved Clinical Trials.**
See Benefits for Clinical Trials.
45. **Transplantation Services.**
Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.
- Donor costs directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.
- Donor costs are limited to donor:
- Identification.
 - Evaluation.
 - Organ removal.
 - Direct follow-up care.
- Expenses for transportation, lodging, and meals for the Insured organ recipient and his or her companion are reimbursable as follows per transplant episode:
- Four one way economy airfares.
 - Two meals per person per day for both the Insured organ recipient and his or her companion.
 - Lodging for up to 45 nights up to the average standard room rate (assumes double occupancy).
- A transplant episode is the time from the initial evaluation for the transplant until 90 days after the Insured organ recipient is discharged from the transplant facility or until the Insured organ recipient is cleared to return home, whichever is sooner.
- 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.
- 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.
46. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits in Sections 19 and 20 of this Certificate.

47. Genetic Testing.

Benefits are limited to genetic testing following genetic counseling when ordered by a Physician and which is determined to be Medically Necessary when an Insured has or is suspected of having a clinical genetic disorder, and when the result of the genetic testing will impact the Insured's treatment. Benefits will be available in the following circumstances:

- When the Insured has obtained genetic counseling.
- For an Insured who is at risk of inheriting or transmitting a genetic disorder.
- To guide medication therapy for the treatment of lymphoma, leukemia, and inflammatory bowel disease.
- For prenatal genetic testing associated with chronic villus sampling and/or amniocentesis.

48. Medical Supplies.

Medical supplies must meet all of the following criteria:

- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

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

49. Sleep Studies.

Benefits are limited to one complete study per lifetime when provided by a practitioner at a sleep facility that is accredited by the American Academy of Sleep Medicine (AASM). A complete study may include more than one session at a sleep study center.

50. TMJ Surgery.

Surgical Treatment for Temporomandibular Joint Dysfunction (TMJ) (for demonstrable joint disease only) or Temporomandibular Disease Syndrome (TMD). Non-surgical treatment of TMJ or TMD is not covered, including but not limited to appliances, behavior modification, physiotherapy, and prosthodontic therapy. Post-operative physical therapy for TMJ surgery is covered when the TMJ surgery is covered under this policy. This physical therapy must be obtained during the 90-day period beginning on the date of the covered TMJ surgery.

Section 7: Mandated Benefits

BENEFITS FOR ACCIDENTAL INGESTION OF A CONTROLLED SUBSTANCE

Benefits will be paid for accidental ingestion or consumption of a controlled drug as required by Connecticut statute. When Inpatient treatment in a Hospital, whether or not operated by the State, is required as a result of accidental ingestion or consumption of a controlled drug, benefits will be paid for the Allowed Amount incurred up to a maximum of 30 days Hospital Confinement. Benefits will also be paid for outpatient treatment resulting from accidental ingestion or consumption of a controlled drug for any one accident.

BENEFITS FOR HYPODERMIC NEEDLES OR SYRINGES

Benefits will be paid for the Allowed Amount incurred for hypodermic needles or syringes prescribed by a licensed Physician for the purpose of administering medications for any Injury or Sickness, provided such medications are covered under the Policy.

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

BENEFITS FOR HOME HEALTH CARE

Benefits will be paid as specified in the Schedule of Benefits for the Covered Medical Expenses incurred for Home Health Care services.

Each visit by a representative of a home health agency shall be considered as one Home Health Care visit; four hours of home health aide service shall be considered as one Home Health Care visit.

If an Insured is eligible for Home Health Care coverage under more than one Policy, the Home Health Care benefits shall only be provided by that Policy which would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

“Home Health Care” means the continued care and treatment of an Insured Person who is under the care of a Physician or an advanced practice registered nurse if:

1. Continued hospitalization would otherwise have been required if Home Health Care was not provided, except in the case of an Insured diagnosed by a Physician or advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, and,
2. The plan covering the Home Health Care is established and approved in writing by such Physician or advanced practice registered nurse within seven days following termination of a hospital confinement as a resident Inpatient for the same or a related condition for which the Insured was hospitalized, except that in the case of an Insured diagnosed by a Physician or advanced practice registered nurse as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such Insured was so confined or, if such Insured was so confined, irrespective of such seven-day period, and
3. Such Home Health Care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a Physician or advanced practice registered nurse as terminally ill with a prognosis of six months or less to live.

Home Health Care shall be provided by a home health agency. “Home health agency” means an agency or organization which meets each of the following requirements:

1. It is primarily engaged in and is federally certified as a home health agency and duly licensed by the appropriate licensing authority to provide nursing and other therapeutic services.
2. Its policies are established by a professional group associated with such agency or organization, including at least one Physician or advanced practice registered nurse and at least one Registered Nurse, to govern the services provided.
3. It provides for full-time supervision of such services by a Physician, an advanced practice registered nurse or by a Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an administrator.

Home Health Care shall consist of, but shall not be limited to, the following:

1. Part-time or intermittent nursing care by a Registered Nurse or by a licensed practical nurse under the supervision of a Registered Nurse, if the services of a Registered Nurse are not available;
2. Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a Registered Nurse or licensed practical nurse;
3. Physical, occupational or speech therapy;
4. Medical supplies, drugs and medicines prescribed by a Physician, advanced practice registered nurse or Physician Assistant and laboratory services to the extent such charges would have been covered under the Policy or contract if the Insured had remained or had been confined in the Hospital;
5. Medical social services provided to or for the benefit of a covered person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live. “Medical social services” mean services rendered, under the direction of a Physician by a qualified social worker, including but not limited to:
 - a. assessment of the social, psychological and family problems related to or arising out of such covered person’s illness and treatment;
 - b. appropriate action and utilization of community resources to assist in resolving such problems;
 - c. participation in the development of the overall plan of treatment for such Insured.

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

BENEFITS FOR MENTAL OR NERVOUS CONDITIONS

Benefits will be paid as specified in the Policy Schedule of Benefits for the diagnosis and treatment of Mental Illness and Substance Use Disorders.

Benefits include, but are not limited to:

1. General Inpatient Hospital Confinement, including in state-operated facilities.
2. Medically Necessary Acute Treatment Services and Medically Necessary Clinical Stabilization Services.
3. General Hospital outpatient services, including at state-operated facilities.
4. Psychiatric Inpatient Hospital Confinement, including in state-operated facilities.
5. Psychiatric outpatient Hospital services, including at state-operated facilities.
6. Intensive outpatient services, including at state-operated facilities.

7. Partial hospitalization, including at state-operated facilities.
8. Evidence-based maternal, infant and early childhood home visitation services that are designed to improve health outcomes for pregnant women, postpartum mothers and newborns and children, including, but not limited to, for maternal Substance Use Disorders or depression and relationship-focused interventions for children with Mental Illness or Substance Use Disorders.
9. Intensive, home-based or evidence-based services designed to address specific Mental Illness in a child or adolescent.
10. Evidence-based family-focused therapy that specializes in the treatment of juvenile Substance Use Disorders.
11. Short-term family therapy intervention.
12. Nonhospital inpatient detoxification.
13. Medically monitored detoxification.
14. Ambulatory detoxification.
15. Inpatient services at psychiatric residential treatment facilities.
16. Rehabilitation services provided in residential treatment facilities, general Hospitals, psychiatric Hospitals or psychiatric facilities.
17. Observation beds in acute Hospital settings.
18. Psychological and neuropsychological testing conducted by an appropriately licensed health care provider.
19. Trauma screening conducted by a licensed behavioral health professional.
20. Depression screening, including maternal depression screening, conducted by a licensed behavioral health professional.
21. Substance use screening conducted by a licensed behavioral health professional.
22. Intensive, family-based and community-based treatment programs that focus on addressing environmental systems that impact chronic and violent juvenile offenders.
23. Other home-based therapeutic interventions for children.
24. Chemical maintenance treatment.
25. Extended day treatment programs at a Day Treatment Center.

“Acute treatment services” means twenty-four hour medically supervised treatment for a Substance Use Disorder that is provided in a medically managed or medically monitored Inpatient facility.

“Clinical stabilization services” means twenty-four hour clinically managed post detoxification treatment, including, but not limited to, relapse prevention, family outreach, aftercare planning and addiction education and counseling.

“Day Treatment Center” means a facility for outpatient therapy, care and training of children and youths who, after appropriate evaluation, are deemed in need of such therapy, care and training.

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

BENEFITS FOR TREATMENT OF TUMORS AND LEUKEMIA

Benefits will be paid the same as any other Sickness for the surgical removal of tumors and for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any non-dental prosthesis, including any maxillofacial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, and a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.

Benefits will be provided for prescribed orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications.

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid for the Allowed Amount incurred for reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Benefits shall be provided for at least forty eight hours of Inpatient care following a mastectomy or lymph node dissection, and may provide for a longer period of Inpatient care if such care is recommended by the Insured's Physician.

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

BENEFITS FOR MAMMOGRAPHY AND COMPREHENSIVE ULTRASOUND SCREENING

Benefits will be paid the same as any other Covered Medical Expenses as shown on the Schedule of Benefits for diagnostic and screening Mammograms for Insureds which are equal to the following requirements:

1. A baseline Mammogram, which may be provided by breast tomosynthesis at the option of the Insured, for any Insured who is:
 - a) Thirty-five to thirty-nine years of age, inclusive.
 - b) Younger than thirty-five years of age if the Insured is believed to be at increased risk for breast cancer due to:
 - i.) A family history of breast cancer.
 - ii.) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene variant that materially increases the Insured's risk for breast cancer.
 - iii.) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest.
 - iv.) Other indications as determined by the Insured's Physician.
2. Mammograms, which may be provided by breast tomosynthesis at the option of the Insured, every year for an Insured who is:
 - a) Forty years of age or older.
 - b) Younger than forty years of age if the Insured is believed to be at increased risk for breast cancer due to:
 - i.) A family history, or prior personal history, of breast cancer.
 - ii.) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Insured's risk for breast cancer.
 - iii.) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest.
 - iv.) Other indications as determined by the Insured's Physician.

"Mammogram" means mammographic examination or breast tomosynthesis, including, but not limited to, a procedure with a HCPCS code of 77051, 77052, 77055, 77056, 77057, 77063, 77065, 77066, 77067, G0202, G0204, G0206 or G0279, or any subsequent corresponding code.

"Healthcare Common Procedure Coding System" or "HCPCS" means the billing codes used by Medicare and overseen by the federal Centers for Medicare and Medicaid Services that are based on the current procedural technology codes developed by the American Medical Association.

Additional benefits will be provided for:

1. Comprehensive diagnostic and screening ultrasounds of an entire breast or breasts if
 - a) A Mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
 - b) An Insured is believed to be at increased risk for breast cancer due to:
 - i) A family history or prior personal history of breast cancer.
 - ii) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Insured's risk for breast cancer.
 - iii) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest.
 - iv) Other indications as determined by the Insured's Physician.
2. Diagnostic and screening magnetic resonance imaging of an entire breast or breasts:
 - a) In accordance with guidelines established by the American Cancer Society for an Insured who is thirty-five years of age or older.
 - b) If an Insured is younger than thirty-five years of age and believed to be at increased risk for breast cancer due to:
 - i) A family history, or prior personal history, of breast cancer.
 - ii) Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Insured's risk for breast cancer.

- iii) Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest.
 - iv) Other indications as determined by the Insured's Physician.
- 3. Breast biopsies.
- 4. Prophylactic mastectomies for an Insured who is believed to be at increased risk for breast cancer due to positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Insured's risk for breast cancer.
- 5. Breast reconstructive surgery for an Insured who has undergone:
 - a) A prophylactic mastectomy.
 - b) A mastectomy as part of the Insured's course of treatment for breast cancer.

No Deductible, Copayment or Coinsurance or other out-of-pocket expenses will be applied to the benefits. Benefits shall be subject to all other provisions of the Policy.

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for laboratory and diagnostic tests, including, but not limited to, prostate specific antigen (PSA) tests to screen for prostate cancer for Insureds who are symptomatic, or whose biological father or brother has been diagnosed with prostate cancer, and for all Insureds fifty (50) years of age or older.

Benefits will also be paid for the treatment of prostate cancer, provided such treatment is Medically Necessary and in accordance with guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

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

BENEFITS FOR OSTOMY APPLIANCES AND SUPPLIES

Benefits will be paid for the Allowed Amount for Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors.

"Ostomy" shall include colostomy, ileostomy and urostomy.

Benefits shall not be applied to any Durable Medical Equipment benefit maximum. Benefits shall be subject to all other Deductible, Copayments, 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, including, but not limited to the following:

1. An annual fecal occult blood test.
2. Colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the Policy; however, benefits will not be subject to any Deductible, Copayments, Coinsurance or out of pocket expense for any additional colonoscopy services ordered by a Physician within a Policy Year.

BENEFITS FOR CLINICAL TRIAL

Benefits will be paid the same as any other Sickness for the Routine Patient Care Costs associated with Clinical Trials.

"Clinical Trial" means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic diseases in Insured Persons.

“Routine Patient Care Costs” means:

1. Medically Necessary health care services that are incurred as a result of treatment being provided to the Insured for purposes of the Clinical Trial that would otherwise be covered if such services were not rendered pursuant to a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Insured during the course of treatment in the Clinical Trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the Insured were not enrolled in a Clinical Trial.
2. Costs incurred for Prescription Drugs provided to the Insured, provided such Prescription Drugs have been approved for sale by the federal Food and Drug Administration. If the Policy provides Preferred Provider benefits, such hospitalization shall include treatment at an Out-of-Network facility if such treatment is not available at a Preferred Provider Hospital and not eligible for reimbursement by the sponsors of such Clinical Trial.

Routine Patient Care Costs shall not include:

1. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration.
2. The cost of a non-health care service that an Insured may be required to receive as a result of the treatment being provided.
3. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial.
4. Costs of services that are: a) inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis; or b) performed specifically to meet the requirements of the Clinical Trial.
5. Costs that would not be covered under the Insured’s Policy for investigational treatments, including, but not limited to, items excluded from coverage under this Policy.
6. Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial for the Insured or any family member or companion.
7. Items and services provided by the research sponsors free of charge for any person taking part in the trial.

The Company may require that the person or entity seeking coverage for the Clinical Trial provide some or all of the following:

1. Evidence satisfactory to the Company that the Insured receiving coverage meets all of the patient selection criteria for the clinical trial, including credible evidence in the form of clinical or pre-clinical data showing that the Clinical Trial is likely to have a benefit for the Insured Person that is commensurate with the risks of participation in the Clinical Trial to treat the Insured Person’s condition.
2. Evidence that the appropriate informed consent has been received from the Insured.
3. Copies of any medical records, protocols, test results or other clinical information used by the Physician or institution seeking to enroll the Insured in the Clinical Trial.
4. A summary of the anticipated Routine Patient Care Costs in excess of the costs for standard treatment.
5. Information from the Physician or institution regarding those items, including any Routine Patient Care Costs, that are eligible for reimbursement by an entity other than the Company, including the entity sponsoring the Clinical Trial.
6. Any additional information that may be reasonably required for the review of a request for coverage of the Clinical Trial. The Company shall request any additional information about a Clinical Trial not later than five business days after receiving a request for coverage from an Insured Person or a Physician seeking to enroll an Insured in a Clinical Trial.

A Clinical Trial for the prevention of cancer shall be eligible for coverage only if it involves a therapeutic intervention, is a phase III Clinical Trial approved by one of the entities identified below and is conducted at multiple institutions. In order to be eligible for coverage of Routine Patient Care Costs, a Clinical Trial shall be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by one of the following:

1. One of the National Institutes of Health.
2. A National Cancer Institute affiliated cooperative group.
3. The federal Food and Drug Administration as part of an investigational new drug or device exemption.
4. The federal Department of Defense or Veterans Affairs.
5. Qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19th, 2000, Medicare National Coverage Determination, as amended from time to time. Benefits will not be provided for any single institution Clinical Trial conducted solely under the approval of the institutional review board of an institution, or any trial that is no longer approved by an entity identified herein.

The provider, Hospital or institution seeking coverage for the Routine Patient Care Costs shall submit to the Company the standardized request for coverage form as developed by the Connecticut Insurance Department to request approval for

Clinical Trial benefits. The Company shall not accept any other approval request form other than the standardized request for coverage form. Upon receipt of the standardized form, the Company shall approve or deny coverage for such services not later than five business days after receiving such request and any other reasonable supporting materials requested by the Company, except that if the Company utilizes independent experts to review such requests, it shall respond not later than ten business days after receiving such request and supporting materials.

The Insured, or the provider with the Insured's written consent, may appeal any denial of coverage for Medical Necessity to an external, independent review pursuant to section 39a-478n of the general statutes. Such external review shall be conducted by a properly qualified review agent whom the Connecticut Department of Insurance has determined does not have a conflict of interest regarding the Clinical Trial.

The Company shall not provide coverage for Routine Patient Care Costs that are eligible for reimbursement by an entity other than the Company, including the entity sponsoring the Clinical Trial.

Routine Patient Care Costs shall be subject to the same Deductibles, Copayments, Coinsurance, terms, conditions, restrictions, exclusions and limitations of the Policy, including limitations on out-of-network care, except that treatment at an out-of-network Hospital shall be made available by the out-of-network Hospital and the Company at no greater cost to the Insured than if treatment was available at a Preferred Provider Hospital.

BENEFITS FOR POSTPARTUM CARE

If an Insured and Newborn Infant are discharged from Inpatient care less than forty-eight hours after a vaginal delivery or less than ninety-six hours after a cesarean delivery, benefits will be provided on the same basis as any other Covered Medical Expenses as shown on the Schedule of Benefits for a follow-up visit within forty-eight hours of discharge and an additional follow-up visit within seven days of discharge. Any decision to shorten the length of Inpatient stay to less than forty-eight hours after a vaginal delivery or ninety-six hours after a cesarean delivery shall be made by the Physician after conferring with the Insured.

Follow-up services shall include, but not be limited to, physical assessment of the Newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any Medically Necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and Newborn pediatric care.

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

BENEFITS FOR AMINO ACID MODIFIED PREPARATIONS AND LOW PROTEIN MODIFIED FOOD PRODUCTS

Benefits will be paid the same as any other outpatient Prescription Drug for Amino Acid Modified Preparations and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if the Amino Acid Modified Preparations or Low Protein Modified Food Products are prescribed for the therapeutic treatment of Inherited Metabolic Diseases and are administered under the direction of a Physician.

"Inherited Metabolic Disease" means: (A) disease for which newborn screening is required under Connecticut Statute Title 38a, Chapter 700c, Section 19a-55; and (B) Cystic Fibrosis.

"Low Protein Modified Food Product means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

"Amino Acid Modified Preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the Medically Necessary treatment of all types of diabetes. For the purposes of this benefit:

“Diabetes Device” means a device, including, but not limited to, a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device or insulin syringe, that is (a) a legend device or nonlegend device, and (b) used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar.

“Diabetic Ketoacidosis Device” means a device that is (a) a legend or nonlegend device, and (b) used to screen or prevent diabetic ketoacidosis.

“Glucagon Drug” means a drug that contains glucagon and is (a) a legend drug or nonlegend drug, (b) prescribed for self-administration on an outpatient basis, and (c) approved by the federal Food and Drug Administration to treat low blood sugar.

“Insulin Drug” means a drug, including, but not limited to, an insulin pen, that contains insulin and is (a) a legend drug or nonlegend drug, (b) prescribed for self-administration on an outpatient basis, and (c) approved by the federal Food and Drug Administration to treat diabetes.

“Noninsulin Drug” means a drug, including, but not limited to, a glucagon drug, glucose tablet or glucose gel, that does not contain insulin and is approved by the federal Food and Drug Administration to treat diabetes.

Benefits shall include but not be limited to:

1. Laboratory and diagnostic testing and screening, including, but not limited to, hemoglobin A1c testing and retinopathy screening.
2. Insulin Drugs (a) prescribed by a Physician, or (b) prescribed and dispensed by a pharmacist once during a Policy Year. Deductible, Copayments, Coinsurance, and other out-of-pocket expenses shall not exceed \$25 dollars for each thirty-day supply for covered Insulin Drugs.
3. Noninsulin Drugs (a) prescribed by a Physician, or (b) prescribed and dispensed by a pharmacist once during a Policy Year if the Noninsulin Drug is a Glucagon Drug. Deductible, Copayments, Coinsurance, and other out-of-pocket expenses shall not exceed \$25 dollars for each thirty-day supply for covered noninsulin drugs.
4. Diabetes Devices in accordance with the Insured’s diabetes treatment plan, including, but not limited to, Diabetes Devices prescribed and dispensed by a pharmacist once during a Policy Year. Deductible, Copayments, Coinsurance, and other out-of-pocket expenses shall not exceed \$100 for a thirty-day supply of Diabetes Devices.
5. Diabetic Ketoacidosis Devices in accordance with the Insured’s diabetes treatment plan, including, but not limited to, Diabetic Ketoacidosis Devices prescribed and dispensed by a pharmacist once during a Policy Year. Deductible, Copayments, Coinsurance, and other out-of-pocket expenses shall not exceed \$100 for a thirty-day supply for Diabetic Ketoacidosis Devices.

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

BENEFITS FOR DIABETIC OUTPATIENT SELF-MANAGEMENT TRAINING

Benefits will be paid the same as any other Sickness for outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a Physician. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a Physician, as defined in the Policy, trained in the care and management of diabetes and authorized to provide such care within the scope of the Physician’s practice. Covered Medical Expenses shall include:

1. Initial training visits provided to an Insured after the Insured is initially diagnosed with diabetes that is Medically Necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, up to a maximum of ten hours.
2. Training and education that is Medically Necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Insured’s symptoms or condition which requires modification of the Insured’s program of self-management of diabetes, up to a maximum of four hours.

3. Training and education that is Medically Necessary because of the development of new techniques and treatment for diabetes up to a maximum of four hours.

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

BENEFITS FOR LYME DISEASE TREATMENT

Benefits will be paid the same as any other Sickness for Lyme disease treatment including not less than thirty days of intravenous antibiotic therapy, sixty days of oral antibiotic therapy, or both, and shall provide benefits for further treatment if recommended by a Physician.

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

BENEFITS FOR INPATIENT DENTAL SERVICES

Benefits will be paid the same as any other Sickness for general anesthesia, nursing and related Hospital services provided in conjunction with Inpatient, outpatient or one day dental services if the following conditions are met:

1. The anesthesia, nursing and related Hospital services are deemed Medically Necessary by the treating Physician.
2. The Insured is either a) a person who is determined by a Physician to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital, or b) a person who has a developmental disability, as determined by a Physician, that places the person at serious risk.

The expense of anesthesia, nursing and related Hospital services shall be deemed a Covered Medical Expense and shall not be subject to any limits on dental benefits in the Policy.

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

BENEFITS FOR TREATMENT OF CRANIOFACIAL DISORDERS

Benefits will be paid the same as any other Sickness for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Insureds eighteen years of age or younger. The processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No benefits are provided for cosmetic surgery.

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

BENEFITS FOR PAIN MANAGEMENT

Benefits will be paid the same as any other Sickness for Pain treatment ordered by a Pain Management Specialist, which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

The Insured will not be required to use, prior to using a brand name prescription drug prescribed by a licensed Physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs.

“Pain” means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves, and “Pain Management Specialist” means a Physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist, radiation oncologist, or physiatrist with additional training in pain management.

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

BENEFITS FOR ISOLATION CARE AND EMERGENCY SERVICES

Benefits will be paid the same as any other Injury or Sickness for isolation care and emergency services provided by the state’s mobile field Hospital.

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

BENEFITS FOR INFERTILITY TREATMENT

Benefits will be paid the same as any other Sickness for an Insured Person for the Medically Necessary expenses of the diagnosis and treatment of Infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. Such infertility treatment must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

For the purposes of this section "Infertility" means the condition of an individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period or such treatment is Medically Necessary.

Benefits are subject to the following limitations:

1. Benefits for ovulation induction are subject to a lifetime limit of four cycles.
2. Benefits for intrauterine insemination are subject to a lifetime limit of three cycles.
3. Benefits for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer, and tubal ovum transfer are subject to a lifetime limit of two cycles, with not more than two embryo implantations per cycle.
4. Benefits for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer are payable only to those Insured Persons who:
 - a. Have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered by this Policy. However benefits will not be denied on this basis for any Insured Person who foregoes a particular infertility treatment or procedure if the Insured Person's Physician determines that such treatment or procedure is likely to be unsuccessful.

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

BENEFITS FOR HEARING AIDS

Benefits will be paid for Medically Necessary hearing aids. Such hearing aids shall be considered Durable Medical Equipment and shall be limited to one hearing aid per ear within a twenty-four month period.

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

BENEFITS FOR AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Mental Illness for the diagnosis and treatment of Autism Spectrum Disorders. Treatment of Autism Spectrum Disorders must be Medically Necessary, and must be prescribed or ordered by a licensed Physician, licensed Psychologist or licensed Clinical Social Worker in accordance with a treatment plan developed by a behavior analyst who is certified by the Behavior Analyst Certification Board, licensed Physician, licensed Psychologist, licensed Clinical Social Worker pursuant to a comprehensive evaluation or reevaluation of the Insured.

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

"Autism Spectrum Disorder" means "autism spectrum disorder" as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

"Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research and consistent with the services and interventions designated by the Commissioner of Developmental Services including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of Insureds diagnosed with Autism Spectrum Disorder, that are: A) Provided to Insureds less than twenty-one years of age; and B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed Physician, or (iii) a licensed Psychologist. Behavioral therapy is "supervised by" such behavior analyst, licensed Physician or licensed Psychologist when such supervision entails at least one hour of face-to-face supervision of the Autism Spectrum Disorder services provider by such behavior analyst, licensed Physician or licensed Psychologist for each ten hours of behavioral therapy provided by the supervised provider.

Treatment for Autism Spectrum Disorders shall include:

1. Behavioral therapy.
2. Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under the Policy.
3. Direct psychiatric or consultative services.
4. Direct psychological or consultative services.
5. Physical therapy.
6. Speech and language pathology services.
7. Occupational therapy.

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

BENEFITS FOR EPIDERMOLYSIS BULLOSA TREATMENT

Benefits will be paid for the Allowed Amount for wound-care supplies that are Medically Necessary for the treatment of Epidermolysis Bullosa provided such benefits are administered under the direction of a Physician.

“Epidermolysis Bullosa” is a genetic disorder caused by a mutation in the keratin gene. The disorder is characterized by the presence of extremely fragile skin and recurrent blister formation, resulting from minor mechanical friction or trauma.

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

BENEFITS FOR HUMAN LEUKOCYTE ANTIGEN TESTING

Benefits will be paid the same as any other Sickness for expenses arising for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantations.

Such testing shall be performed in a facility a) accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and b) certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time.

Benefits are limited to Insured Persons who, at the time of such testing, complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the Policy; however, any Deductible, Copayment, Coinsurance or other out of pocket expense shall not exceed 20% of the cost of the testing Per Policy Year.

BENEFITS FOR BLOOD LEAD SCREENING

Benefits will be paid for the Allowed Amount for blood lead screening and risk assessment ordered by an Insured's primary Physician.

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

BENEFITS FOR PROSTHETIC DEVICES

Benefits will be paid the same as Durable Medical Equipment for prosthetic devices that are at least equivalent to those provided under Medicare. Benefits include the Medically Necessary repair or replacement of a prosthetic device as determined by the Insured's Physician, unless such repair or replacement is necessitated by misuse or loss.

Benefits are limited to a prosthetic device that is determined by a Physician to be the most appropriate to meet the medical needs of the Insured.

“Prosthetic device” means an artificial limb device to replace, in whole or in part, an arm or a leg, including a device that contains a microprocessor if such microprocessor-equipped device is determined by the Insured's Physician to be Medically Necessary. Prosthetic device does not include a device that is designed exclusively for athletic purposes.

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

BENEFITS FOR MENTAL HEALTH WELLNESS EXAMS

Benefits will be paid for the Allowed Amount for two mental health wellness examinations per year if conducted by a Licensed Mental Health Professional or Physician.

“Mental Health Wellness Examination” is a screening or assessment to identify any behavioral or mental health needs and appropriate treatment resources. It may include:

1. Observation.
2. A behavioral health screening.
3. Education and consultation on healthy lifestyle changes.
4. Referrals to ongoing treatment, mental health services, and other necessary supports.
5. Discussion of potential medication options.
6. Age-appropriate screenings or observations to understand the Insured's mental health history, personal history, and mental or cognitive state.
7. Relevant input from an adult through screenings, interviews, or questions if appropriate.

“Licensed Mental Health Professional” is one of the following licensed professionals:

1. A professional counselor or certain people practicing under supervision.
2. A Physician certified in psychiatry.
3. An advanced practice registered nurse (APRN) certified as a psychiatric and mental health clinical nurse specialist or practitioner.
4. A psychologist.
5. A marital and family therapist.
6. A clinical social worker.
7. An alcohol and drug counselor.

The Policy Deductible, Copayment, Coinsurance limitations, or any other limitations will not be applied to this benefit.

BENEFITS FOR OVARIAN CANCER SCREENINGS AND SERVICES

Benefits will be paid the same as any other Sickness for the following screening services:

1. Genetic testing for Insureds having a family history of breast or ovarian cancer.
2. Routine screening procedures for ovarian cancer and the office or facility visit for such screening, including surveillance tests for ovarian cancer for Insureds who are at risk for ovarian cancer, when ordered or provided by a Physician.
3. CA-125 monitoring of ovarian cancer subsequent to treatment.
4. Genetic testing of the breast cancer gene one, breast cancer gene two, and other gene variant that materially increases the Insured's risk for breast and ovarian cancer or other gynecological cancer to detect an increased risk for breast and ovarian cancer when recommended by a Physician in accordance with the United States Preventive Services Task Force recommendations for testing.

“At risk for ovarian cancer” means:

1. Having a family history:
 - a. With one or more first degree blood relatives, including a parent, sibling or child, or one or more second degree blood relatives, including an aunt, uncle, grandparent, grandchild, niece, nephew, half-brother or half-sister with ovarian or breast cancer; or
 - b. Of nonpolyposis colorectal cancer; or
2. Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene variant that materially increases the Insured's risk for breast cancer, ovarian cancer or any other gynecological cancers.

“Surveillance tests for ovarian cancer” means an annual screening using:

1. CA-125 serum tumor marker testing.
2. Transvaginal ultrasound.
3. Pelvic examination; or

4. Other ovarian cancer screening tests currently being evaluated by the United States Food and Drug Administration or by the National Cancer Institute.

No Deductible, Copayment or Coinsurance or other out-of-pocket expenses will be applied to the benefits. Benefits shall be subject to all other provisions of the Policy.

BENEFITS FOR CORONARY CALCIUM SCANS

Benefits will be paid the same as any other Sickness for Coronary Calcium Scans.

“Coronary Calcium Scan” means a computed tomography scan of the heart that looks for calcium deposits in the heart arteries.

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

BENEFITS FOR BIOMARKER TESTING

Benefits will be provided the same as any other Sickness for Biomarker Testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of an Insured's disease or condition that is supported by medical and scientific evidence, including but not limited to one or more of the following:

1. Approval or clearance of such test by the federal Food and Drug Administration or recommendations on labels of drugs approved by the federal Food and Drug Administration to conduct such test.
2. National coverage determinations or local coverage determinations for Medicare Administrative Contractors by the Centers for Medicare and Medicaid Services.
3. Nationally recognized clinical practice guidelines. Such policy shall provide such coverage in a manner that limits disruptions in care, including, but not limited to, the need for multiple biopsies or biospecimen samples.

“Biomarker” means a characteristic, including, but not limited to, a gene mutation or protein expression that can be objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention for a disease or condition.

“Biomarker testing” means the analysis of an Insured's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, tests for a single substance, tests for multiple substances and diseases or conditions. Biomarker Testing does not include an evaluation of how an Insured feels, functions or survives.

“Clinical utility” means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs an Insured's outcome and impacts the clinical decision.

“Nationally Recognized Clinical Practice Guidelines” means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing transparent methodologies and reporting structures and conflict-of-interest policies.

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

Section 8: Coordination of Benefits Provision

Premium for each Insured Person will be paid by the Policyholder.

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

Definitions

1. **Allowable Expenses:** Any health care expense, including Coinsurance, or Copays and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health Plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C)

of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.

- The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
- For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
- For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
- If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

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

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

Plan includes all of the following:

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

Plan does not include any of the following:

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

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

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

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

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

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

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

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

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

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

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

1. **Non-Dependent/Dependent.** The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the Plan covering the person as a dependent; and (ii) primary to the Plan covering the person as other than a dependent, then the order of benefit is reversed. The Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.
2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
 - the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
 - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
3. **Dependent Child/Parents Divorced, Separated or Not Living Together.** If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

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

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

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

If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:

- First, the Plan of the parent with custody of the child.
- Then the Plan of the spouse of the parent with the custody of the child.
- The Plan of the parent not having custody of the child.
- Finally, the Plan of the spouse of the parent not having custody of the child.

4. **Dependent Child/Non-Parental Coverage.** If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.
5. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
 - Second, the benefits under the COBRA or continuation coverage.
 - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

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

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate its liability to be the lesser of:

- What the plan would have paid if it had been primary.
- The balance of billed charges.

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

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

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

Section 9: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If an accidental injury shall independently of all other causes and within 365 days from the date of injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

Life	\$10,000.00
Two or More Members	\$10,000.00
One Member	\$5,000.00

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

Section 10: Definitions

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

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

Allowed amounts are based on the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States. Experimental treatment does not include a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the Sickness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INJURY means accidental bodily injuries sustained by the Insured Person which: 1) are the direct cause, independent of disease or bodily infirmity or any other cause; 2) are treated by a Physician within 30 days after the date of accident; and occurs while this policy is in force. 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 the Policy.

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

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

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit.

Intensive care does not mean any of these step-down units:

1. Progressive care.
2. Sub-acute intensive care.
3. Intermediate care units.

4. Private monitored rooms.
5. Observation units.
6. Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in any of the following:

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

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

MEDICAL NECESSITY/MEDICALLY NECESSARY means health care services that a Physician, exercising prudent clinical judgement, would provide to an Insured for the purpose of preventing, evaluating, diagnosing or treating Sickness, Injury, or its symptoms, and that are all of the following:

1. In accordance with Generally Accepted Standards of Medical Practice.
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured's Sickness or Injury.
3. Not primarily for the convenience of the Insured, Physician or other health care provider and 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 the Insured's Sickness or Injury.

For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgement.

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

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. Mental illness does not include (1) intellectual disabilities, (2) specific learning disorders, (3) motor disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. If not excluded or defined elsewhere in the Policy, all mental health or psychiatric diagnoses are considered one Sickness.

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

NEWBORN INFANT means: 1) a newly born child of the Insured from the moment of birth provided that person is insured under this Policy; 2) a child adopted by the Insured provided the person adopting the child is insured under this Policy on the date the adoption becomes effective; and 3) a child who has been placed for adoption with the Insured, even though the adoption has not been finalized, provided the child lives in the household of the Insured and is dependent upon the Insured for support and maintenance. Such child will be covered under the Policy for the first 91 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; and 3) the date of placement of the child for adoption. Coverage for such a child will be for Injury or Sickness, including medically diagnosed Congenital Conditions, birth abnormalities, prematurity and nursery care. Benefits will be the same as for the Insured Person who is the child's parent.

OUT-OF-NETWORK PROVIDER means a provider who does not have a contract with the Company to provide services to Insured Persons.

OCCUPATIONAL THERAPY means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a duly licensed Physician or an advanced practice registered nurse (APRN) who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility. Such plan shall be reviewed and certified at least every two months by such Physician or APRN. "Health care facility" means an institution which provides occupational therapy, including, but not limited to, an outpatient clinic, a rehabilitative agency and a skilled or intermediate nursing facility.

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

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

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

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

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

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

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

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

PRESCRIPTION DRUGS means any of the following:

1. Prescription legend drugs.
2. Compound medications of which at least one ingredient is a prescription legend drug.
3. Any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician.
4. Injectable insulin.

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

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

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

1. An *All Payer Model Agreement* if adopted.
2. State law.

3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

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

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

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

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

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

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

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

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

TELEHEALTH/TELEMEDICINE means live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology that is compliant with Public Act 24-110. The site may be an originating facility or another location such as an Insured Person's home or place of work. Telehealth includes audio-only telephone services.

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Insured unable to actively attend class.

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

URGENT CRISIS CENTER means a center licensed by the Department of Children and Families that is dedicated to treating children's urgent mental or behavioral health needs.

Section 11: 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. Acne.
2. Acupuncture, except as specifically provided in the Benefits for Pain Management.
3. Addiction, such as:
 - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
4. Alternative treatments, such as:
 - Hypnosis.
5. Biofeedback.
6. Cosmetic procedures, except reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
7. Custodial Care, except as specifically provided in the Benefits for Mental or Nervous Conditions.

- Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
8. Dental treatment, except:
- For accidental Injury to Sound, Natural Teeth.
 - As specifically provided in the Schedule of Benefits.
- This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
9. Elective Surgery or Elective Treatment.
10. Elective abortion.
11. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline, or chartered aircraft only while participating in a school sponsored intercollegiate sport activity.
12. Foot care for the following:
- Flat foot conditions.
 - Subluxations of the foot.
 - Fallen arches.
 - Weak feet.
 - Chronic foot strain.
 - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).
- This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
13. Genetic testing, except as specifically provided in the Policy.
14. Health spa or similar facilities. Strengthening programs.
15. Hearing examinations. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
- This exclusion does not apply to:
- Hearing defects or hearing loss as a result of a Congenital Condition, infection, or Injury.
 - Hearing aids specifically provided for in the Benefits for Hearing Aids. -
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation. We will not exclude coverage under this Plan for a sole proprietor who is eligible for, but who does not elect, Workers' Compensation. Subject to applicable state law or to the extent permissible by law.
17. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
18. Injury sustained while:
- Participating in any 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.
19. Investigational services.
20. Lipectomy.
21. Motor vehicle Injury.
22. Participation in a riot, civil disorder or a felony, except when Injury occurs when the Insured Person has an elevated blood alcohol content or when under the influence of intoxicating liquor or any drug or both. Participation means to voluntarily take a part or share with others assembled together in some activity. Riot means a violent public disturbance of the peace by a number of persons assembled together.
23. Personal care, comfort, or convenience items not directly related to the treatment of a Sickness or Injury.
24. Prescription Drugs, services or supplies as follows:
- Therapeutic devices or appliances, including: hypodermic needles, and syringes, except for hypodermic needles or syringes prescribed by a Physician for the purpose of administering medications for medical conditions, provided such medications are covered under the Policy, support garments and other non-medical substances, except as specifically provided in the Policy.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs. except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacist's American Hospital Formulary Service Drug Information (AHFS-DI).
 - Products used for cosmetic purposes.

- Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
25. Reproductive services for the following, except as specifically provided in the Policy:
- Procreative counseling.
 - Genetic counseling and genetic testing, except as specifically provided in the Policy.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except as specifically provided in the Benefits for Infertility Treatment.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
26. 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 for a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the Sickness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase III clinical trial of the Federal Food and Drug Administration; or except as specifically provided in the Policy.
27. 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 benefits specifically provided in the Policy.
28. Services provided without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee for which the Insured is not charged.
29. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except as specifically provided in the Benefits for Treatment of Craniofacial Disorders. Temporomandibular joint dysfunction, except as specifically provided in the Policy.
30. Skydiving. Hang gliding. Parasailing. Sail planing. Bungee jumping.
31. Sleep disorders, except as specifically provided in the Policy.
32. Speech therapy, except as specifically provided in the Policy. Naturopathic services that are not Covered Medical Expenses in the Policy.
33. Supplies, except as specifically provided in the Policy.
34. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Benefits for Reconstructive Breast Surgery and Benefits for Treatment of Tumors and Leukemia or as specifically provided in the Policy. This exclusion does not apply to breast reduction surgery for treatment of Gender Dysphoria.
35. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
- Recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle, four-wheeled all terrain vehicle (ATV), jet ski, ski cycle, or snowmobile.
36. Treatment in a Government hospital for which the Insured is not charged, unless there is a legal obligation for the Insured Person to pay for such treatment.
37. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
38. Weight management. Weight reduction. Nutrition programs. Treatment for obesity except for Nutritional Counseling for obesity (or except morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Section 12: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/MyAccount or submit claims by mail. If submitting by mail, send to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.

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

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

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

Section 13: General Provisions

GRACE PERIOD: A grace period of 14 days will be provided for the payment of each premium payment due after the first premium. The Insured Person's premium must be received during the grace period to avoid a lapse in coverage, and the Insured Person must meet the eligibility requirements each time a premium payment is made.

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

CLAIM FORMS: Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after first requesting such forms, the Insured Person shall be deemed to have complied with the requirements as to the proof of loss upon submitting to the Insured, within 90 days written proof covering the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required. Written proof of loss must be submitted to the Company at P.O. Box 809025, Dallas, Texas 75380-9025 within 90 days after expense is incurred, or as soon thereafter as reasonably possible.

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, be paid directly to the Hospital or person rendering such service, unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss.

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

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

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

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

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

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

Section 14: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL

Standard Internal Appeal

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

The written Internal Appeal request should include:

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

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

Internal Appeal Process

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

Upon receipt of the request for an Internal Review, the Company shall provide the Insured Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company. With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate individual(s) who have been designated to conduct Utilization Review. The individual(s) shall not have been involved in the initial Adverse Determination.

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

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

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

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

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

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

1. For a Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.

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PLEASE NOTE:

The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.

2. For a Concurrent Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance
3. For a Retrospective Review, the notice shall be made no later than 60 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 of such reviewer's understanding of the Insured Person's grievance;
4. The reviewer's decision in clear terms and the Policy contract basis for such decision in sufficient detail for the Insured Person to respond further to the Company's position;
5. Reference to the evidence or documentation used as the basis for the decision;
6. 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;
7. For an Internal Review decision that upholds the Company's original Adverse Determination:
 - a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
 - b. Reference to the specific Policy provisions upon which the determination is based;
 - c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
 - d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
 - e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
 - f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
8. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
9. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
10. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

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

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

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

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

Expedited Internal Review Process

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

1. Involving Urgent Care Requests; and

2. Related to a Concurrent Review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Authorized Representative shall be notified of the EIR decision no more than forty-eight hours after the Company receives such request or seventy-two (72) hours after the Company's receipt of the EIR request if any portion of such forty-eight-hour period falls on a weekend.

If the EIR request is related to an Urgent Care Request for a substance use disorder, co-occurring mental disorder, or for a mental disorder requiring (i) Inpatient services, (ii) partial hospitalization, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep an Insured Person from requiring an Inpatient setting, the Insured Person or the Authorized Representative shall be notified of the EIR decision no more than twenty-four (24) hours after the Company's receipt of the EIR request.

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

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

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

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

RIGHT TO EXTERNAL INDEPENDENT REVIEW

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

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

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

1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days 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 120 days to request an External Independent Review. All requests for an External Independent Review shall be made in writing to the Commissioner.

Where to Send External Review Requests

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

Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816
(800) 203-3447
Email: insurance@ct.gov

Standard External Review (SER) Process

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

1. Within five business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. The Insured Person has exhausted the Company's Internal Appeal Process;
 - c. The Insured Person has provided all the information and forms necessary to process the request; and
 - d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within one business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
3. After receiving notice that a request is eligible for SER, the Commissioner shall, within one business day:
 - a. Assign an Independent Review Organization (IRO) from the Commissioner's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4.
 - a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within one business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
 - b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
 - c. If the Company reverses its decision, the Company shall provide written notification within one business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

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

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Commissioner at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and

- The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
- b. A Final Adverse Determination, if:
 - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received Emergency Services, but has not been discharged from a facility.
- 2. An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
- 3. Upon receipt of an EER request, the Commissioner shall immediately review the request to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
 - c. The Insured Person has provided all the information and forms necessary to process the request; and
 - d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
- 4. Immediately after completion of the review, the Company shall notify the Commissioner, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
- 5. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an Independent Review Organization (IRO) from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
 - a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
 - b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
- 6.
 - a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
- 7. In no more than forty-eight hours after the IRO receives the assignment from the Commissioner to conduct the review or 72 hours after receipt of the qualifying EER request if any portion of such forty-eight-hour period falls on a weekend, the IRO shall:
 - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
 - b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.
- 8. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Standard Experimental or Investigational Treatment External Review (SEIER) Process

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

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

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or

- investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Commissioner.
2. Within five business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
 - b. The recommended or requested health care services or treatment:
 - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - Standard health care services or treatments are not medically appropriate for the Insured Person;
 - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. The Insured Person's treating Physician:
 - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. The Insured Person has exhausted the Company's Internal Appeal Process; and
 - f. The Insured Person has provided all the information and forms necessary to process the request.
 3. Within one business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
 - b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
 4. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within one business day:
 - a. Assign an IRO from the Commissioner's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
 5.
 - a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
 6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
 7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
 - b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.

8. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational Treatment External Review (EEIER) Process

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

1. An Insured Person or an Authorized Representative may make an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the Commissioner at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
 - The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or
 - b. A Final Adverse Determination, if:
 - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to gain maximum function; or
 - The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.
2. An EEIER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
3. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:
 - a. The individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
 - b. The recommended or requested health care services or treatment:
 - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
 - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - Standard health care services or treatments are not medically appropriate for the Insured Person;
 - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. The Insured Person's treating Physician:
 - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. The Insured Person has exhausted the Company's Internal Appeal Process unless the Insured person is not required to do so as specified in sub-sections 1. a. and b. above; and
 - f. The Insured Person has provided all the information and forms necessary to process the request.
4. The Company shall immediately notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or

- b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
5. After receiving notice that a request is eligible for EEIER, the Commissioner shall immediately:
 - a. Assign an IRO from the Commissioner's approved list; and
 - b. Notify the Company of the name of the assigned IRO.
6. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
7.
 - a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
8.
 - a. The Company shall, within five business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the EEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
9. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
10. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
 - b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
11. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than five calendar days after being selected by the IRO.
12. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
13. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

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

APPEAL RIGHTS DEFINITIONS

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

Adverse Determination means: the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under the Company's health benefit plan requested by an Insured Person or an Insured Person's Physician, based on a determination by the Company or its designee utilization review company:

1. That, based upon the information provided, (I) upon application of any utilization review technique, such benefit does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or (II) is determined to be experimental or investigational;
2. Of an Insured Person's eligibility to participate in the Company's health benefit plan; or

3. Any Prospective Review, Concurrent Review or Retrospective Review determination that denies, reduces terminates or fails to provide or make payment, in whole or in part, for a benefit under the Company's health benefit plan requested by an Insured Person or an Insured Person's Physician.

Adverse determination includes a rescission of coverage determination for grievance purposes.

Authorized Representative means:

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

Clinical Peer means a Physician or other health care professional who:

1. for a review other than one specified under this section, holds a nonrestricted license in a state of the United States in the same specialty as the treating Physician or other health care professional who is managing the medical condition, procedure or treatment under review.
2. for an urgent care review concerning:
 - a. A child or adolescent substance use disorder or a child or adolescent mental disorder, holds:
 - A national board certification in child and adolescent psychiatry.
 - A doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable.
 - b. An adult substance use disorder or an adult mental disorder, holds:
 - A national board certification in psychiatry.
 - A doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

Concurrent Review means utilization review conducted during an Insured Person's stay or course of treatment in a facility, the office of a Physician or other inpatient or outpatient health care setting, including home care.

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

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

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

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

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, or health care settings. Such techniques may include the monitoring of or evaluation of (1) health care services performed or provided in an outpatient setting, (2) the formal process for determining, prior to discharge from a facility, the coordination and management of the care that an

Insured Person receives following discharge from a facility, (3) opportunities or requirements to obtain a clinical evaluation by a Physician other than the one originally making a recommendation for a proposed health care service, (4) coordinated sets of activities conducted for individual patient management of serious, complicated, protracted or other health conditions, or (5) Prospective Review, Concurrent Review, Retrospective Review or certification.

Questions Regarding Appeal Rights

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

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

Consumer Ombudsman's Office
Connecticut Office of the Healthcare Advocate
P. O. Box 1543
Hartford, CT 06144
(866) 466-4446
www.ct.gov/oha/healthcare.advocate@ct.gov

Section 15: Online Access to Account Information

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

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

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

Section 16: ID Cards

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

Section 17: UHCSR Mobile App

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

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

Section 18: Important Company Contact Information

The Policy is Underwritten by:

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:

UnitedHealthcare Student Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-800-767-0700

Website: www.uhcsr.com

Sales/Marketing Services:

UnitedHealthcare Student Resources

11399 16th Court North, Suite 110

St. Petersburg, FL 33716

Email: info@uhcsr.com

Customer Service:

800-767-0700

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

Section 19: Pediatric Dental Services Benefit

Benefits are provided for Covered Dental Services, as described below, for Insured Persons under the age of 26. Benefits terminate on the last day of the Policy Year the Insured Person reaches the age of 26; or 2) the date the Insured Person's coverage under the Policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

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

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

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

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

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

What Are Covered Dental Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are provided. Benefits payable for Medically Necessary treatment for which pre-authorization was not obtained will be reduced by 50% of the scheduled benefit or \$500 per occurrence, whichever is less.

Section 2: Benefits for Pediatric Dental Services

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

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

Network Benefits:

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

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

Out-of-Network Benefits:

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

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

Benefits

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

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

Benefit Description

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
Diagnostic Services		
<i>Evaluations (Checkup Exams)</i> Limited to two times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient D0160 - Detailed and extensive oral evaluation - problem focused, by report	100%	100%
<i>Intraoral Radiographs (X-ray)</i> Limited to two series of films per 12 months. D0210 - Intraoral – comprehensive series of radiographic images D0709 - Intraoral - comprehensive series of radiographic images – image capture only D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	100%	100%
The following services are limited to two per 12 months. D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0374 - Intraoral tomosynthesis - periapical radiographic image D0389 - Intraoral tomosynthesis - periapical radiographic image – image capture only D0706 - Intraoral - occlusal radiographic image	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
- image capture only D0707 - Intraoral - periapical radiographic image - image capture only		
Any combination of the following services is limited to two series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only D0708 - Intraoral - bitewing radiographic image - image capture only	100%	100%
Limited to one time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only	100%	100%
The following service is limited to two images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	100%	100%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	100%	100%
Preventive Services		
<i>Dental Prophylaxis (Cleanings)</i> The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	100%	100%
Fluoride Treatments The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride -	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
excluding varnish		
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	100%	100%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral per quadrant D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular	100%	100%
D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant		
Minor Restorative Services		
<i>Amalgam Restorations (Silver Fillings)</i> The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
<i>Composite Resin Restorations (Tooth Colored Fillings)</i> The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces (anterior) D2989 - Excavation of a tooth resulting in the determination of non-restorability	100%	100%
Crowns/Inlays/Onlays		
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2740 - Crown - porcelain/ceramic D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth	100%	100%
The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown	100%	100%
The following service is not subject to a frequency limit.	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
D2940 - Placement of interim direct restoration		
The following services are limited to one time per tooth every 60 months. D2950 - Core buildup, including any pins when required D2951 - Pin retention - per tooth, in addition to restoration	100%	100%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	100%	100%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	100%	100%
Endodontics		
The following services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration) D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	100%	100%
The following services are not subject to a frequency limit. D3310 - Endodontic therapy, anterior tooth (excluding final restoration) D3320 - Endodontic therapy, premolar tooth (excluding final restoration) D3330 - Endodontic therapy, molar tooth (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - premolar D3348 - Retreatment of previous root canal therapy - molar	100%	100%
The following services are not subject to a frequency limit.	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit		
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy premolar (first root) D3425 - Apicoectomy molar (first root) D3426 - Apicoectomy (each additional root) D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	100%	100%
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	100%	100%
Periodontics		
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	100%	100%
The following services are limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
tissue		
The following services are limited to one every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft - retained natural tooth - first site in quadrant D4286 - Removal of non-resorbable barrier	100%	100%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure	100%	100%
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns	100%	100%
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	100%	100%
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	100%	100%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
Removable Dentures		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5282 - Removable unilateral partial denture one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth)	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture – mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture per tooth D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace missing or broken teeth - partial denture per tooth D5650 - Add tooth to existing partial denture - per tooth D5660 - Add clasp to existing partial denture	100%	100%
The following services are limited to rebasing performed more than six months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
denture (per arch)		
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	100%	100%
Bridges (Fixed partial dentures)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic	100%	100%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	100%	100%
The following services are limited to one time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal		
The following services are not subject to a frequency limit. D6930 - Re-cement or re-bond FPD D6980 - FPD repair necessitated by restorative material failure	100%	100%
Oral Surgery		
The following services are not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal, impacted teeth only	100%	100%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	100%	100%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth	100%	100%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, - per quadrant D7320 - Alveoloplasty not in conjunction with extractions four or more teeth or tooth spaces, per quadrant	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, - per quadrant		
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	100%	100%
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst D7510 - Incision and drainage of abscess, intraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva	100%	100%
The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	100%	100%
Adjunctive Services		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative treatment of dental pain - per visit	100%	100%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration	100%	100%
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	100%	100%
The following services are limited to one guard every 12 months.	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch		
Implant Procedures		
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement: transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast	100%	100%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments D6081 - Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing, and increased pocket depths, includes cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6089 - Accessing and retorquing loose implant screw per screw D6090 - Repair of implant/abutment supported prosthesis D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
replacement D6105 - Removal of implant body not requiring bone removal nor flap elevation D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6180 - Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments D6190 - Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6193 - Replacement of an implant screw D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant		
The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant D6107 - Guided tissue regeneration - non-resorbable barrier, per implant	100%	100%
Medically Necessary Orthodontics		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits shall include one replacement retainer per lifetime. Benefits are available only when the service or supply is determined to be medically Necessary.		

PLEASE NOTE:

The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Out-of-Network Benefits
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8671 - Periodic orthodontic treatment visit associated with orthognathic surgery D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular	100%	100%

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that

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PLEASE NOTE:

The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.

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

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

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

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

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

Covered Dental Service - a Dental Service or Dental Procedure for which benefits are provided under this provision.

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

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

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

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

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

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

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

- Necessary to meet the basic dental needs of the Insured Person.
- Provided in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:

- Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
- Safe with promising efficacy
 - For treating a life threatening dental disease or condition.
 - Provided in a clinically controlled research setting.
 - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

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

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

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

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

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

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

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

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

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

Section 20: Pediatric Vision Services Benefit

Pediatric Vision Care Services Benefits

Benefits are provided for Vision Care Services, as described below, for Insured Persons under the age of 26. Benefits terminate on the last day of the Policy Year the Insured Person reaches the age of 26; or 2) the date the Insured Person's coverage under the Policy terminates.

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

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

Policy Deductible

Benefits for pediatric Vision Care Services provided 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.

What Are the Benefit Descriptions?**Benefits**

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

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

Frequency of Service Limits

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

Routine Vision Examination

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

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

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

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

Eyeglass Lenses

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

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

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

Eyeglass Frames

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

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

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

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

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

Necessary Contact Lenses

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

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

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

Schedule of Benefits

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

Eyeglass Frames	Once per year.	\$40 Copayment	50% of the billed charge.
• Eyeglass frames with a retail cost up to \$130.			50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - \$160.			50% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - \$200.			50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - \$250.			50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.			50% of the billed charge.
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	\$40 Copayment	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	\$40 Copayment	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

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 Pediatric Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile(fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

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

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

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

Section 21: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

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

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

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

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

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

Copayment or Coinsurance Amount

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

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

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

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

If an Insured purchases a Prescription Drug Product from an out-of-Network Pharmacy and does not file a claim for reimbursement with the Company, the Insured can receive credit towards their In-Network Annual Deductible, Prescription Drug Deductible, or Out-of-Pocket Limit for their out-of-pocket expenses if they submit proof of payment and they paid less than the average discounted rate for such Prescription Drug Product paid to a Network Pharmacy.

A proof of payment form is available at <https://www.uhc.com/member-resources/pharmacy-benefits> under the Submission for Out-of-Network Credit Frequently Asked Questions.

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

The Insured Person is not responsible for paying a Copayment and/or Coinsurance for Prescription Drug Products on the List of Zero Cost Share Medications.

How Do Supply Limits Apply?

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

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

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

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject, from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed. For Prescription Drug Products that allow a 90-day fill, the Insured may be required to obtain a limited number of up to 31-day fills until the maintenance dose is established.

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

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

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

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

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

Designated Pharmacies

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

If the Insured is directed to a Designated Pharmacy and does not obtain their Prescription Drug Product from a Designated Pharmacy, benefits will be paid under the out-of-network Prescription Drug Benefit.

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Do Prior Authorization Requirements Apply?

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

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

Prescription Drug Products which require notification are:

Abilify MyCite, Abrilada, Actemra/Actemra ACT pen (subcutaneous formulation), Acthar, Actimmune, Actiq, Adalimumab-aacf (unbranded Idacio), Adalimumab-adaz (unbranded Hyrimoz), Adalimumab-adbm (unbranded Cyltezo), Adalimumab-fkip (unbranded Hulio), Adalimumab-ryvk (unbranded Simlandi), Adbry, Adcirca, Addyi, Adempas, Adynovate, Afinitor Disperz, Afinitor/Torpenz, Afrezza, Agamree, Aimovig, Ajovy, Akeega, Aklied, Albuterol Tablets, Alcenza, Alkindi Sprinkle, Alhemo, Alyftrek, Altreno, Alunbrig, Alvaiz, Alyq, Amitiza, Amjevita, Ampyra, Andembry, Androderm, Androgel packets and pump, Anzupgo, Apokyn, Aptiom, Aqneursa, Aquoral, Arazlo, Arbli, Arcalyst, Arikayce, Aspruzo, Atopaderm, Atorvaliq, Atralin, Attruby, Aubagio, Augtyro, Austedo/Austedo XR, Auvelity, Avita cream & gel, Avmapki Fakzynja Co-Pack, Avonex, Ayvakit, Bafiertam, Balversa, Banzel (brand only), Belbuca, Benlysta, Berinert, Besremi, Betaseron, Bethkis, Bimzelx, Bonjesta, Bosulif, Braftovi, Brenzavvy, Brexafemme, Briviact, Bronchitol, Brukinsa, Bulk Powders, Buphenyl, Butrans, Bydureon Bcise, Byetta, Bylvay, Cablivi, Cabometyx, Calquence, Camzyos, Caphosol, Caplyta, Caprelsa, Carbaglu, Carospir, Cayston, Cequa, Cerdelga, Cetrotide, Chlorpromazine, Cholbam, Cibringo, Cimzia, Cinryze, Cobenfy, Codeine/phenylephrine/promethazine, Codeine/promethazine, Cometriq, Continuous Glucose Monitors – Dexcom Receiver/Sensor/Transmitter, Continuous Glucose Monitors – Guardian REAL-Time Continuous Glucose Monitoring System, Copaxone, Copiktra, Corlanor, Cosentyx, Cotellic, Crenessity, Ctexli, Cuvrior, Cyltezo, Cystadrops, Cystaran, Danziten, Daraprim, Daurismo, Dawnzera, Daybue, Demser, Depakote (brand only), Depakote ER (brand only), Devices – Skin conditions, Diacomit, Diclegis, Differin Cream, gel & lotion, Dojolvi, Doptelet, Duopa, Dupixent, Duragesic, Duvyzat, Ebglyss, Egrifta, Eleton/Eleton Twinpack, Eligard, Elocate, Emflaza, Emgality, Empaveli, Endari, EndeavorRX, Entresto, Entty, Entyvio Pen, Envarsus XR, Eohilia, Epaned, Epclusa, EpiCeram, Epidiolex, Eprontia, Epsolay, Ergomar, Erivedge, Erleada, Ermeza, Esbriet, Eversense Sensor, Transmitter, Evrysdi, Exjade, Exkivity, Exservan, Extavia, Ezallor Sprinkles, Fabhalta, Fabior, Fasenna, Felbatol, Fentanyl citrate bulk powder, Fentanyl Transdermal Patches, Fentora, Feriprox, Filspari, Filsuvez, Fintepila, Firazyr, Firdapse, First-Lansoprazole, First-Omeprazole, Fleqsy, Flolipid, Flowtuss, Fortamet, Forteo, Fortesta Gel, Forzinity, Fotivda, Freestyle diabetes test strips, Freestyle Libre, Fruzaqla, Furoscix, Fycompa, Galafold, Gattex, Gavreto, Genotropin, Gilenya, Gilotrif,

Glatopa, Glumetza, Gomekii, Gonal-F/Gonal-F RFF, Grastek, Hadlima/HadlimaPushtouch, Haegarda, Halucort, Harliku, Harvoni, Hemlibra, Hernexeos, Hetlioz, Hetlioz LQ, HPR/HPR Plus, Hulio, Humatrope, Humira, Hycamtin, Hyclodex, Hydrocodone/homatropine, Hydromorphone XR (generic Exalgo), Hyftor, Hylaguard, Hylatopic/Hylatopic Plus, Hymvapzi, Hyrimoz, Hysingla ER, Ibrance, Ibsrela, Iclusig, Idacio, Idhifa, Ilumya, Imbruvica, Imkeldi, Imuldosa, Inbrija, Increlex, Indocin suppository/suspension, Infergen, Ingrezza, Inluriyo, Inlyta, Inqovi, Inrebic, Intrarosa, Inzirgo, Iqirvo, Iressa, Isturisa, Itovebi, Ivermectin, Iwilfin, Jadenu/Jadenu Sprinkles, Jakafi, Jascayd, Jatenzo, Jaypirca, Joenja, Jublia, Juxtapid, Jylamvo, Jynarque, Kalydeco, Kamdoy, Katerzia, Keppra (brand only), Keppra XR (brand only), Kerendia, Kerydin, Kesimpta, Kevesis, Kevzara, Kineret, Kisqali, Kitabis Pak, Komzifti, Korlym, Koselugo, Kuvan, Kyzatrex, Lamictal, Lamictal ODT (brand only), Lamictal XR (brand only), Lazcluze, Lenvima, Leqembi LQLIK, Leqselvi, Letairis, Leuprolide, Levemir, Libervant, Lidoderm, Linzess, Liqrev, Litfulo, Lithobid, Livdelzi, Livmarli, Lokelma, Lonsurf, Lopressor, Lorbrema, Lotronex, Lucemyra, Lumakras, Lumryz, Lupkynis, Lybalvi, Lynkuet, Lynparza, Lyrica (brand only), Lytgobi, Lyvispah, Mavenclad, Mavyret, Mayzent, Medtronic Enlite Sensor, Medtronic Mini-Link Transmitter, Medtronic Sof-sensor, Mekinist, Mektovi, Meloxicam, Methodone (generic Dolophine), Methyldopa, Miebo, Migranal, Miplyffa, Mirvaso, Morphine sulfate ER (generic Avinza), Morphine sulfate ER (generic Kadian), Motegrity, Motpoly XR, Mounjaro, Movantik, MS Contin, Mulpleta, Multaq, Myalept, Mycapssa, Myfembree, Mysoline, Mytesi, Naprosyn Suspension, Natesto, Nayzilam, Nemludio, Neocara, Neosalus / Neosalus Cp, Nerlynx, Neurontin, Neutrasal, Nexavar, Nexium packets, Nexlatol, Nexlizet, Ngenla, Ninlaro, Nityr, Nocdurna, Norliqva, Northera, Nourianz, Nubeqa, Nucala, Nucynta/Nucynta ER, Nuedexta, Nuplazid, Nurtec ODT, Nutraseb, Nutropin/Nutropin AQ, Nutropin AQ NuSpin, Ocaliva, Octreotide Acetate, Odactra, Odomzo, Ofev, Ogsiveo, Ohtuvayre, Ojemda, Ojjaara, Olpruva, Olumiant, Omnipod 5, Omnitrope, Omnitrope Pen 5,10, Ompreparazole + Suspend SF Alka, Omtryg, Omvoh, Onfi (brand only), Onureg, Opsumit, Opsynvi, Opzelura, Oralair, Orenica/Orenica Clickjet (subcutaneous formulation), Orenitram, Orfadin, Orgovyx, Oriahnn, Orlissa, Orkambi, Orladeyo, Orserdu, Osphena, Otezla/Otezla XR, Otulfi, Oxervate, Oxymorphone ER (generic Opana ER), OxyContin, Ozempic, Palforzia, Palsonify, Palynziq, Pemazyre, Penlen, Pheburane, Phexxi, Piqray, Plegrixy, Pomalyst, Ponvory, Pradaxa (pellet pack), Praluent, Prevacid Solutab, Prevymis, Procysbi, Prograf Granules, Promacta, Promiseb, Prudoxin, Pulmozyme, Purified Cortrophin Gel, Pyrukynd, Pyzchiva, Qbrelis, Qdolo, Quelbree, Qfitlia, Qinlock, Qlosi, Qulipta, Radicava ORS, Ragwitek, Radelsy, Ravicti, Rebif / Rebif Rebidose, Recorlev, Regranex, Relistor, Renvela, Relyvrio, Renvela, reSET, reSET-O, Restasis Multidose vial, Restasis Single dose vial, Retevmo, Retin-A Gel (brand only), Retin-A Cream (brand only), Retin-A Micro, Revlimid, Revuforj, Reyvow, Rezdiffra, Rezurock, Rhapsido, Rhofade 1% Pump, Rinvoq ER/Rinvoq LQ, Rivfloza, Romvimza, Rozyltre, Rubraca, Ruconest, Rukobia, Rybelsus, Rydapt, Sabril, Saizen, Sajazir, Salivamax, Samsca, Sandostatin, Scemblix, Selarsdi, Selzentry, Serostim, Signifor, Sildenafil, Siliq, Simlandi, Simponi, Skyclarys, Skyrizi, Skytrofa, Slynd, Sogroya, Sohonos, Solaraze, Somavert, Somryst, Sotylize, Sotykto, Sovaldi, Spevigo, Spravato, Sprycel, Starjemza, Stelara, Stendra, Steqeyma, Stivarga, Strensiq, Suboxone, Sucraid, Sunlenca, Sunosi, Sutent, Symdeko, Sympazan, Symproic, Syndros, Synderm, Spyryne, Tabrecta, Tadiq, Tafenlar, Tagrisso, Takhzyro, Taltz, Talzenna, Tarceva, Tarpeyo, Tascenso ODT, Tasinga, Tavalisse, Tavneos, Tazorac cream & gel, Tecfidera, Tegsedi, Tepmetko, Teriparatide, Testim, Testosterone topical gel, Tetrabenazine, Tetric, Tezspire, Tezruly, Thalomid, Tibsovo, Tiqlutik, Tirosint-Sol, Tlando, TOBI, TOBI Podhaler, Tonmya, Topamax (brand only), Topiramate extended-release sprinkle (brand only), Tracleer, Tremfya, Trikafta, Trileptal (brand only), Trudhesa, Trulance, Trulicity, Truqap, Tryngolza, Tryptyr, Tukysa, Turalio, Tussicaps, Tussionex, Tuxarin, Tyenne, Tykerb, Tymlos, Tyrvaya, Tyvaso, Ubrelvy, Upneeq, Upravi, Ustekinumab-twe, Vafseo, Valchlor, Valsartan Oral Solution, Valtoco, Vanflyta, Vanrafia, Vascepa, Vecamyl, Velsipity, Veezoh, Veltressa, Vemlidy, Venclexta, Ventavis, Veezoh, Verkazia, Verquvo, Verzenio, Vevye, Viberzi, Victroza Vigafyde, Vijoice, Vimpat (brand only), Vitrakvi, Vivjoa, Vizimpro, Vizz, Vogelxo, Vonjo, Voranigo, Voquezna, Vosevi, Votrient, Vowst, Voxzogo, Vtama, Vuity, Vumerity, Vykate XR, Vyleesi, Vyndaqel, Vyndamax, Vyvgart Hytrulo, Wainua, Wakix, Wayrilz, Welireg, Wezlana, Winlevi, Winrevair, Xalkori, Xcopri, Xdemvy, Xeljanz, Xeljanz XR, Xelstrym, Xermelo, Xifaxin, Xiidra, Xolair, Xolremdi, Xospata, Xphozah, Xpovio, Xromi, Xtampza ER, Xtandi, Xuriden, Xyntha, Xyntha Solofuse, Xyosted, Xyrem, Xywav, Yesintek, Yeztugo, Yorvipath, Yuflyma, Yupelri, Yusimry, Yutrepia, Zavzpret, Zegerid packets, Zejula, Zelboraf, Zelnorm, Zelsuvmi, Zepatier, Zeposia, Zilbrysq, Zilxi, Zohydro ER, Zokinvy, Zolanza, Zomacton, Zonalon, Zonegran, Zonisade, Zorbtive, Zoryve, Ztalmi, ZTLido, Zurzuvae, Zydelig, Zykadia, Zymfentra

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

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

When the Insured submits a claim on this basis, the Insured may pay more because they did not obtain prior authorization from the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Copayment or Coinsurance and any Deductible that applies.

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

Does Step Therapy Apply?

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. Unless Medical Necessity dictates otherwise, in order to receive benefits for such Prescription Drug Products an Insured must use a different Prescription Drug Product(s) first.

The Company may not require the use of step therapy for: (1) any Prescription Drug Product for longer than thirty days, (2) a Prescription Drug Product for cancer treatment for an Insured who has been diagnosed with stage IV metastatic cancer provided such Prescription Drug is in compliance with approved federal Food and Drug Administration indications, (3) for the treatment of schizophrenia, major depressive disorder or bipolar disorder, as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, or (4) any Prescription drug Product for the treatment of multiple sclerosis or rheumatoid arthritis.

Prescription Drug Products subject to step therapy requirements are:

Actemra/Actemra ACT pen (subcutaneous formulation), Acthar, Agamree, Aimovig, Ajovy, Akeega, Alhemo, Apidra/Apidra Solostar, Auvelity, Azstarys, Berinert, Besremi, Bimzelx, Bosulif, Braftovi, Brenzavvy, Bronchitol, Brukinsa, Caplyta, Cayston, Cetrotide, Chenodal, Cloderm, Cordran Crexont, Crinone, Cutivate lotion, Desonate, Dulera, Elmiron, Emflaza, Emgality, Eucrisa, Extavia, Extina, Farxiga, Fetzima, Fiasp/Fiasp Flex, Fosrenol Chewable Tablets, Fruzaqla, Glyxambi, Gonal-F/Gonal-F RFF, Harvoni, Ibrance, Ibsrela, Ilumya, Inrebic, Insulin Delivery Devices – CeQur Simplicity, InPen, Invokamet, Invokamet XR, Invokana, Iqirvo, Janumet, Janumet XR, Januvia, Jornay PM, Jublia, Juxtapid, Kerydin, Ketoprofen/Ketoprofen ER, Kevzara, Klisyri, Kineret, Lescol XL, Levorphanol Tartrate, Livalo, Livdelzi, Lorbrena, Lyrica CR, Mavenclad, Mekinist, Mektovi, Methyl dopa, Mirabegron ER, Motegrit, Movantik, Nexium packets, Nexletol, Nexlizet, Novolin 70/30, Novolin N, Novolin R, Novolin/Novolin Mix, Novolog, Novolog Mix 70/30, Novolog/Novolog Mix/Novolog Flexpen, Nurtec ODT, Ocaliva, Olumiant, Orencia/Orencia Clickjet (subcutaneous formulation), Oxistat Cream, Palynziq, Pancreaze, Pertzye, Praluent, Prevacid SoluTab, Procysbi, Protopic, Purified Cortrophin Gel, Qfittia, Qtern, Qulipta, Ravicti, Relistor, Reyvow, Rubraca, Rytary, Savaysa, Segluromet, Siliq, Slynd, Solosec, Sovaldi, Sprix, Steglatro, Steglujan, Taltz, Talzenna, Tasinga, Topiramate extended-release sprinkle, Travatan Z, Trintellix, Troxyca, Trulance, Tyenne, Ubrelvy, Ultravate, Velporo, Velsipity, Veregen Viokace, Voquezna, Vumerity, Xatmep, Xhance, Xigduo XR, Xyntha, Xyntha Solofuse, Zavzpret, Zegerid packets, Zelnorm, Zeposia, Zilxi, Zioptan, Zituvio, Zituvimet, Zituvimet XR, Zylflo CR

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

When Does the Company Limit Selection of Pharmacies?

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

Coverage Policies and Guidelines

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

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

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

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

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

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company will pass a portion or all of these rebates on to the Insured. When rebates are passed on to the Insured, they will be taken into account in determining the Insured's Copayment, Coinsurance, Deductible, and out-of-pocket expenses.

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

Certain Prescription Drug Products, including Specialty Prescription Drug Products, are eligible for coupons or offers from pharmaceutical manufacturers or affiliates that may reduce the cost for the Insured's Prescription Drug Product. If the Insured chooses to use such a coupon or offer, the amount of the coupon will be credited toward their Copayment, Coinsurance, Deductible or other out-of-pocket expense for the Prescription Drug Product.

Definitions

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified as appropriate for proposed use in any of the following:
 - AHFS Drug Information (AHFS DI) under therapeutic uses section.
 - Elsevier Gold Standard's Clinical Pharmacology under the indications section.
 - DRUGDEX Xystemby Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb.
 - National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

Exceptions:

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

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

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

Network Pharmacy means a pharmacy that has:

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

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

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

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

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

PPACA means Patient Protection and Affordable Care Act of 2010.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for a Medical Emergency.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
5. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received. We will not exclude coverage under this Plan for a sole proprietor who is eligible for, but who does not elect, workers' compensation. Subject to applicable state law or to the extent permissible by law.
8. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
9. General vitamins, except the following, which require a Prescription Order or Refill:
 - Prenatal vitamins.
 - Vitamins with fluoride.
 - Single entity vitamins.
10. Certain Prescription Drug Products that are repackaged, relabeled, or packaged as (a) unit dose(s).
11. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
12. Prescription Drug products used for cosmetic or convenience purposes.
13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee, except that such review and approval of new Prescription Drug Products and/or new dosage forms will not be required for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for a least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in a substantially accepted peer-reviewed medical literature.
14. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)
15. The following over-the-counter drugs and products:
 - Drugs or products available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter drug or product as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.

- Over-the-counter continuous glucose monitors.

The following Prescription Drug Products with over-the-counter alternatives:

- Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year.
- Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year.

The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.

16. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.
17. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product, unless a Medical Necessity. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product, unless a Medical Necessity. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
19. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another available Prescription Drug Product or pharmaceutical product, unless a Medical Necessity, otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
20. A Prescription Drug Product with either:
 - An approved biosimilar.
 - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product, unless a Medical Necessity.

For the purpose of this exclusion a “biosimilar” is a biological Prescription Drug Product approved based on both of the following:

- It is highly similar to a reference product (a biological Prescription Drug Product).
- It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

21. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
22. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
25. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
26. A Prescription Drug Product that contains marijuana, including medical marijuana unless prescribed as a treatment for pain management.
27. Prescription Drug Products prescribed by a provider who is on the Company's list of excluded providers due to fraud, waste, and/or abuse findings.

Right to Request an Exclusion Exception

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

Please note, if the request for an exception is approved, the Insured may be responsible for paying the higher of:

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

Urgent Requests

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

External Review

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

Expedited External Review

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

Right to Request an Exception for Contraceptives

In accordance with PPACA requirements, an exception process may apply to certain Prescription Drug Products prescribed for contraception if your Physician determines that a Prescription Drug Product alternative to a PPACA Zero Cost Share Preventive Care Medication is Medically Necessary for the Insured Person.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to an Insured Person's health or ability to regain maximum function.

If a request for an exception is approved by the Company, Benefits provided for the Prescription Drug Product will be treated the same as a PPACA Zero Cost Share Preventive Care Medication.

For more information, please visit www.uhcprovider.com under the following path: *Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act \$0 Cost-Share Preventive Medications Exemption Requests (Commercial Members)*.

Schedule of Benefits

Fairfield University

2026-282-1

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 86.170%

Injury and Sickness Benefits

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

Deductible Preferred Provider	\$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	\$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80%, except as listed below
Coinsurance Out-of-Network Provider	50%, except as listed below
Out-of-Pocket Maximum Preferred Provider	\$6,350 (Per Insured Person, Per Policy Year)

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

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

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. "Network area" means the area around the local school campus the Named Insured is attending where access to a Preferred Provider would not cause unreasonable travel time or distance.

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

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

Out-of-Country Claims: Covered Medical Expenses incurred outside the United States will be paid at the Out-of-Network Provider Benefit level.

Copays: When a Copay applies, the Copay will cover all Covered Medical Expenses provided at the point of service. Multiple Copays will not be assessed for specific services received in one setting.

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

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

COL-17-CT (PY26) SOB PPO

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PLEASE NOTE:

The rates referenced are applicable to the plan design. UnitedHealthcare Student Resources may require to change the rates and/ or the plan design to comply with federal or state laws, regulations, or direction.

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

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount after Deductible	Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	\$40 Copay per visit 100% of Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Physiotherapy Limits per Policy Year as follows: 40 visits of physical therapy 40 visits of occupational therapy 40 visits of speech therapy	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Separate physical, occupational, and speech therapy limits apply to rehabilitative and Habilitative Services. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.		
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	\$175 Copay per visit 100% of Allowed Amount after Deductible	\$175 Copay per visit 100% of Allowed Amount after Deductible
Diagnostic X-ray Services	Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Tests & Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit for additional information.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy \$5 Copay per prescription Tier 1 \$40 Copay per prescription Tier 2 \$40 Copay per prescription Tier 3 up to a 30-day supply per prescription \$40 Copay per prescription Specialty not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay or Coinsurance (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	50% billed charge up to a 30-day supply per prescription not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible
Durable Medical Equipment See also Benefits for Prosthetic Devices in the Certificate	Allowed Amount after Deductible	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Consultant Physician Fees	\$40 Copay per visit 100% of Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only. See also Benefits for Inpatient Dental Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid for removal of impacted wisdom teeth only. See also Benefits for Inpatient Dental Services	100% of Allowed Amount after Deductible	100% of Allowed Amount after Deductible
Gender Dysphoria Treatment	Paid as any other Sickness	Paid as any other Sickness
Mental Illness Treatment See also Benefits for Mental or Nervous Conditions	Inpatient: Allowed Amount after Deductible Outpatient office visits: \$40 Copay per visit 100% of Allowed Amount not subject to Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: Allowed Amount not subject to Deductible	Inpatient: Allowed Amount after Deductible Outpatient office visits: 80% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible
Substance Use Disorder Treatment See also Benefits for Mental or Nervous Conditions	Inpatient: Allowed Amount after Deductible Outpatient office visits: \$40 Copay per visit 100% of Allowed Amount not subject to Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: Allowed Amount not subject to Deductible	Inpatient: Allowed Amount after Deductible Outpatient office visits: 80% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible
Maternity See also Benefits for Postpartum Care	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	Allowed Amount after Deductible
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 and Benefits for Diabetic Outpatient Self-Management Training	Paid as any other Sickness	Paid as any other Sickness
High Cost Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Home Health Care This benefit is not subject to the Policy Deductible See Benefits for Home Health Care	Allowed Amount not subject to Deductible	80% of Allowed Amount not subject to Deductible
Hospice Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Inpatient Rehabilitation Facility 90 days maximum per Policy Year	Allowed Amount after Deductible	Allowed Amount after Deductible
Skilled Nursing Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	\$75 Copay per visit 100% of Allowed Amount not subject to Deductible	\$75 Copay per visit 100% of Allowed Amount not subject to Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Approved Clinical Trials See Benefits for Clinical Trial	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Genetic Testing	Paid as any other Sickness	Paid as any other Sickness
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Allowed Amount after Deductible	Allowed Amount after Deductible
Sleep Studies	Paid as any other Sickness	Paid as any other Sickness
TMJ Surgery	Paid as any other Sickness	Paid as any other Sickness
Chiropractic Care 30 visits maximum per Policy Year	\$40 Copay per visit 100% of Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Adult Vision Exam (age 26 and older) Routine eye examination once every 12 months.	Allowed Amount after Deductible	80% of Allowed Amount after Deductible

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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



President

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

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

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

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

Assistance and Evacuation Benefits

DEFINITIONS

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

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

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

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

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

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

MEDICAL EVACUATION AND REPATRIATION BENEFITS

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

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

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

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

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

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

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

CONDITIONS AND LIMITATIONS

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

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

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

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

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

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

Additional Assistance Services

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

MEDICAL ASSISTANCE SERVICES

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

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

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

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

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, the Company's affiliate or authorized vendor will coordinate the transfer of the medication or vaccine to Insured Persons upon the prescribing physician's authorization, if it is legally permissible.

Updates to Family, Employer, and Home Physician: Upon an Insured Person's approval, the Company's affiliate or authorized vendor will provide periodic case updates to appropriate individuals designated by the Insured Person in order to keep them informed.

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

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

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, an Insured Person can contact the Company's affiliate or authorized vendor to have a pre-trip destination report sent to the Insured Person. This report draws upon an intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. The global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

TRAVEL ASSISTANCE SERVICES

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

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

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

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

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

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

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

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

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at www.uhcsr.com/MyAccount and select My Benefits/Additional Benefits/UHC Global Emergency Services.

When calling the Emergency Response Center, the caller should be prepared to provide the following information:

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

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

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

Notice of Non-Discrimination

We¹ comply with the applicable civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

We provide free aids and services to help you communicate with us. You can ask for interpreters and/or for communications in other languages or formats such as large print. We also provide reasonable modifications for persons with disabilities.

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

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

If you need help with your complaint, please call **1-866-260-2723** for Medical Plans, **1-800-638-3120** for Vision Plans, **1-877-816-3596** for Dental Plans. (TTY 711).

You can also file a complaint with the U.S. Dept. of Health and Human Services, Office for Civil Rights:

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

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

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

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

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

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

NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND ALTERNATE FORMATS

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

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

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

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

ចំណាំ: អ្នកអាចស្នើសុំអ្នកបកប្រែ ដើម្បីទំនាក់ទំនងជាមួយគ្រូពេទ្យរបស់អ្នក នៅពេលណាដែល ឬនិយាយជាមួយយើងខ្ញុំ។ បើសិនអ្នកនិយាយ**កម្ពុជាខ្មែរ (Cambodian Mon-Khmer)** មានសេវាជំនួយកម្ពុជា ដោយឥតគិតថ្លៃ ការទំនាក់ទំនងដោយឥតគិតថ្លៃ ក្នុងទម្រង់ផ្សេងទៀត ដូចជាអត្ថប្រយោជន៍ មានសម្រាប់អ្នក។ សូមហៅទូរស័ព្ទទៅ **1-866-260-2723** សម្រាប់ការប្រាប់ដឹងសម្រាប់ **1-800-638-3120** សម្រាប់ការប្រាប់ដឹងទៅផ្នែក **1-877-816-3596** សម្រាប់ការប្រាប់ដឹងទៅផ្នែក ឬហៅទូរស័ព្ទទៅលេខទូរស័ព្ទដោយមិនគិតថ្លៃ ដែលបានចុះក្នុងបញ្ជីសមាជិករបស់អ្នក។ (TTY: 711)។

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

ATENSYON: Siña hao humosga un intérprete para kumuentos yan i doktermu gi ora di i konsulta-mu pat yan hame. Yanggen fifino' hao **CHamoru (Chamorro)**, guaha setbisio siha para hãgu ni' mandibãtdi, i setbision fino' pat lengguãhi yan fina'uma'espiahi gi otro na manera siha, taiguihi i para mana'dãngkolo i inemprenta. Kãlle **1-866-260-2723** para Planã Mediku, **1-800-638-3120** para Planã Visión, **1-877-816-3596** para Planã Dental, pat kãlle i númeru gratut na teleponu na esta pã'go gi kãtta ID para miembro -mu. (TTY: 711).

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

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

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

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

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

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

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

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

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

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

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

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

주의: 진료 시 의사와 상담하거나 저희와의 소통을 위해 통역사 서비스를 받으실 수 있습니다.

한국어(Korean)를 사용하시는 경우 무료 언어 지원 서비스와 큰 활자체 등 다른 형식으로 된 의사 소통 매체를 이용하실 수 있습니다. 의료 플랜의 경우 **1-866-260-2723**, 안과 플랜의 경우

1-800-638-3120, 치과 플랜의 경우 **1-877-816-3596**번으로 전화하거나 귀하의 회원 ID 카드에 기재된 무료 전화번호로 전화하십시오. (TTY: 711).

ໝາຍເຫດ: ທ່ານສາມາດຂໍນາຍແປພາສາເພື່ອເຂົ້າກັບທ່ານໝໍໃນເວລາທີ່ທ່ານນັດໝາຍ ຫຼື ກັບພວກເຮົາໄດ້. ຖ້າວ່າທ່ານເວົ້າ **ພາສາລາວ (Lao)**, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ ແລະ ການສື່ສານພຣີໃນຮູບແບບອື່ນໆ, ເຊັ່ນ: ການພິມຂະໜາດ ໃຫຍ່, ແມ່ນມີໃຫ້ທ່ານ. ໂທ **1-866-260-2723** ສໍາລັບແຜນການທາງການແພດ, **1-800-638-3120** ສໍາລັບແຜນການທາງສາຍຕາ, **1-877-816-3596** ສໍາລັບແຜນການທາງແຂ້ວ, ຫຼື ໂທຫາເບີໂທພຣີທີ່ລະບຸໄວ້ໃນບັດປະຈຳຕົວສະມາຊິກຂອງທ່ານ.(TTY: 711).

SHOOH: Nánihoot'áani góne' ne'azee' íl'íni bich'í' yáńíti' doodago nihí nihich'í' yáńíti' go ata' halne'í' í' í' naayílt'eehgo bíighah. **Diné (Navajo)** bizaad bee yáńíti'to, t'áá jiik'eh saad bee áka'e'eyeed bee áka'anída'ow'í dóó t'áá jiik'eh nááná íahgo át'éego bee hada'dilyaaígíí bee ahít hane', díí nitsaago bik'e'ashchíní, ná dahólq. Ats'íis Nánél'jiih Bee Hada'dít'éhí biniiyé kohjii' 1-866-260-2723 hodíilnih, Anáá' Bee Hoot'íni Bee Hada'dít'éhí biniiyé kohjii' 1-800-638-3120 hodíilnih, Awoo' Bee Hada'dít'éhí biniiyé kóhji' 1-877-816-3596 hodíilnih, doodago bee nít ha'dít'éhí ninaaltsoos nít'ízi bee nééhóziní ID bąąh t'áá jiik'eh námboo bee dahane'í biká'ígíí bee hodíilnih. (TTY: 711).

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

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

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

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

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

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

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

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

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

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

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

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

توجہ فرمائیں: آپ اپنی ملاقات کے وقت یا ہمارے ساتھ اپنے ڈاکٹر سے بات کرنے کے لیے مترجم حاصل کر سکتے ہیں۔ اگر آپ اردو (Urdu) بولتے ہیں، تو مفت لسانی معاونتی خدمات اور دیگر فارمیٹس مثلاً بڑے پرنٹ میں مفت مواصلات آپ کے لیے دستیاب ہیں۔ میڈیکل پلانز کے لیے **1-866-260-2723** پر، ویژن پلانز کے لیے **1-800-638-3120**، ڈینٹل پلانز کے لیے **1-877-816-3596** پر کال کریں، یا
TTY: 711) ۱

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

POLICY NUMBER: 2026-282-1

NOTICE:

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

NOC 1 - 08/14/2026

Certificate:

Removed the page 12 wording from SOB Out of Country claims

From:

Out-of-Country Claims: Covered Medical Expenses incurred outside the United States will be paid at the Out-of-Network Provider Benefit level. pg 12

To:

Out-of-Country Claims: Covered Medical Expenses incurred outside the United States will be paid at the Out-of-Network Provider Benefit level.