UNIVERSITY OF NEW ORLEANS
Lakefront Campus

This Certificate of Coverage is Part of Policy # 2017-701-76

This Certificate of Coverage (“Certificate”) is part of the contract between UnitedHealthcare Insurance Company (hereinafter referred to as the “Company”) 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.

Health care services may be provided to the Insured Person at a Network health care facility by facility-based Physicians who are not in the health plan. The Insured Person may be responsible for payment of all or part of the fees for those Out-of-Network services, in addition to applicable amounts due for Copayments, Coinsurance, Deductibles, and non-covered services. Specific information about the Preferred Provider and Out-of-Network facility-based Physicians can be found at the website address of the health plan or by calling the health plan’s customer service telephone number.

NOTICE: THE INSURED'S SHARE OF THE PAYMENT FOR COVERED MEDICAL SERVICES MAY BE BASED ON AN AGREEMENT BETWEEN THE COMPANY AND THE INSURED'S PROVIDER. UNDER CERTAIN CIRCUMSTANCES, THE AGREEMENT MAY ALLOW THE PROVIDER TO BILL THE INSURED FOR AMOUNTS UP TO THE PROVIDER'S REGULAR BILLED CHARGES.

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

Welcome to the UnitedHealthcare StudentResources Student Injury and Sickness Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company (“the 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.

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.

To receive the highest level of benefits from the plan, the Insured Person should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the plan’s web site at www.uhcsr.com/uno. The web site 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; toll free, for assistance in finding a Preferred Provider.

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 StudentResources
P.O. Box 809025
Dallas, TX 75380-9025

Section 1: Who Is Covered

The Master Policy covers students and their eligible Dependents 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 registered Domestic students taking four or more credit hours, graduate students taking 3 or more credit hours and students taking online courses who also have 3 hours of non-internet coursework, as well as non-F-1 IELP students, are eligible to enroll in this insurance plan on a voluntary basis. All registered International students in F and J status taking credit hours, as well as IELP students in F-1 status, are automatically enrolled in this insurance plan on a hard-waiver basis. All International J-1 scholars and Optional Practical Training and Academic Training students are eligible to enroll in this insurance plan on a voluntary basis.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student’s legal spouse or Domestic Partner and dependent children or grandchildren who meet the limits of a Dependent set forth in the Dependent definition. See the Definitions section of this Certificate for the specific requirements needed to meet Domestic Partner eligibility.

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.

The eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse or a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate.
   b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 12, 2017. 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 16, 2018. The Insured Person’s coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Section 3: Extension of Benefits after Termination

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

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

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

Section 4: Pre-Admission Notification

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

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

2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS**: The patient, patient’s representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission 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 Information

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

UnitedHealthcare Options PPO
The availability of specific providers is subject to change without notice. A list of Preferred Providers is located on the plan’s web site at www.uhcsr.com/uno. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

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

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

Out-of-Network Providers - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

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

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

Continuity of Care; Termination of Provider Contracts
In the event a contract or agreement between the Company and health care provider is terminated, the health care provider shall notify the Company of any Insured who has begun a course of treatment by the provider before the effective date of the termination. Based on this notice from the health care provider, the Company shall notify the Insured of a termination of a health care provider from the Company’s network and the Insured’s right to continuity of care for Covered Medical Expenses that are covered or payable under the terms of the Policy. The following provisions shall be applicable whether such termination is initiated by the Company or the health care provider:

1. In the event an Insured has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth week of pregnancy, the Insured shall be allowed to continue receiving Covered Medical Expenses, subject to the consent of the treating health care provider, through delivery and postpartum care related to the pregnancy and delivery while covered under this Policy.
2. In the event an Insured has been diagnosed with a life-threatening Sickness, the Insured shall be allowed to continue receiving Covered Medical Expenses, subject to the consent of the treating health care provider, until the course of treatment is completed, not to exceed three months from the effective date of such termination while covered under this Policy.
3. In the event a treating health care provider advises the Company of an Insured who meets the criteria above, the Company shall continue payment of the Company liability to the health care provider that was in effect prior to the termination of the contract or agreement with such health care provider. In addition, the contractual requirements for the health care provider to follow the Company’s utilization management and quality management policies and procedures shall remain in effect for the applicable period specified.

The provisions shall not apply when:
1. The reason for such termination is due to suspension, revocation, or applicable restriction of the health care provider’s license to practice in this state by the Louisiana State Board of Medical Examiners, or for another documented reason related to quality of care.

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2. The Insured chooses to change health care providers.
3. The Insured moves out of the geographic service area of the health care provider or health insurance issuer.
4. The Insured requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

Section 6: Medical Expense Benefits – Injury and Sickness

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 hereeto. Read the Definitions section and the Exclusions and Limitations section carefully.

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

Inpatient

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

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

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

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

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

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

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

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

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

   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 (except chiropractic care).

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, vocal nodules, or cleft lip and cleft palate when prescribed by a Physician to improve or restore speech language deficits or swallowing deficits.

17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
• The facility charge for use of the emergency room and supplies.
All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.

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

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

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

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

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

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

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

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

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

Benefits are allowed for early refills of topical ophthalmic Prescription Drugs under the following circumstances:
- The refill is requested by the Insured for a 30-day supply, between 23 and 30 days from the later of either the original date the prescription was distributed or the date the most recent refill was distributed to the Insured.
- For a 60-day supply, between 46 and 60 days from the later of either the original date the prescription was distributed or the date the most recent refill was distributed to the Insured.
- For a 90-day supply, between 69 and 90 days from the later of either the original date the prescription was distributed or the date the most recent refill was distributed to the Insured.

The prescriber of the original topical ophthalmic prescription must indicate that additional quantities are necessary. Refills shall not exceed the number of additional quantities indicated on the original prescription.

**Other**

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

Benefits include Medically Necessary transportation of:
• A Newborn Infant to the nearest Hospital or neonatal special care unit for the treatment of a Sickness, Injury, Congenital Condition, and complications of a premature birth.

• A temporarily medically disabled mother of a Newborn Infant when accompanying the infant to the nearest Hospital or neonatal special care unit, upon recommendation by the mother’s attending Physician.

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

For the purposes of this benefit, the following are considered durable medical equipment.
• Braces that stabilize an injured body part and braces to treat curvature of the spine.
• External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
• Orthotic devices that straighten or change the shape of a body part.

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 and Prosthetic Services.

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

28. **Dental Treatment and Oral Surgery.**
Dental treatment and oral surgery when services are performed by a Physician and limited to the following:
• Excision of tumors or cysts (excluding odontogenic cysts) of the jaws, gums, cheeks, lips, tongue, roof of and floor of the mouth.
• Extraction of impacted teeth.
• Dental care and treatment including surgery and dental appliances required to correct accidental Injuries of the jaws, cheeks, lips, tongue, roof of or floor of the mouth, and of Sound, Natural Teeth.
• Excision of exostoses or tori of the jaws and hard palate.
• Incision and drainage of abscess and treatment of cellulitis.
• Incision of accessory sinuses, salivary glands, and salivary ducts.
• Anesthesia for the above services or procedures when rendered by an oral surgeon.
• Anesthesia for the above services or procedures when rendered by a dentist who holds all required permits or training to administer such anesthesia.
• Anesthesia when rendered in a Hospital setting and for associated Hospital charges when an Insured’s mental or physical condition requires dental treatment to be rendered in a Hospital setting. Anesthesia benefits are not available for treatment rendered for temporomandibular joint (TMJ) disorders.

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

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

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

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

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

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.

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

33. **Preventive Care Services.**
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

Benefits include:
- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of mastectomy, including lymphedemas.

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

Benefits will be paid for Medically Necessary:
- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.

36. **Home Health Care.**
Services received from a licensed home health agency that are:
- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person’s home.
- Pursuant to a home health plan.

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

Benefits also include Private Duty Nursing services when both:
• The Insured's Physician certifies that the services are Medically Necessary.
• The services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care professional.

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

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

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

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

Benefits shall also be provided for a Medically Necessary Day Rehabilitation Program in place of services received at an Inpatient Rehabilitation Facility. The Day Rehabilitation Program must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

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

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

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

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

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

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

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

“Approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

43. Transplantation Services.
Same as any other Sickness for organ, tissue, and bone marrow transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense. Benefits are limited to the following:
- Immunosuppressive drugs prescribed for transplant procedures.
- Solid human organ transplants as specified below:
  - Liver.
  - Heart.
  - Lung.
  - Kidney.
  - Pancreas.
  - Small bowel.
  - Other solid organ transplant procedures, which the Company determines have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. These solid organ transplants will be considered on a case-by-case basis.
- Tissue transplant procedures (autologous and Allogeneic) as specified below:
  - Blood transfusions.
  - Autologous parathyroid transplants.
  - Corneal transplants.
  - Bone and cartilage grafting.
  - Skin grafting.
  - Autologous islet cell transplants.
  - Other tissue transplant procedures, which the Company determines have become standard, effective practices and have been determined to be effective procedures by peer reviewed literature as well as other resources used to evaluate new procedures. These tissue transplants will be considered on a case by case basis.
- Bone marrow transplants. Allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions are covered.

Acquisition Expenses. If a solid organ, tissue or bone marrow is obtained from a living donor for a covered transplant, the donor’s Covered Medical Expenses are covered as acquisition costs for the recipient. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.

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

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

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

44. Pediatric Dental and Vision Services.
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits sections.
45. **Cleft Lip and Cleft Palate.**
Same as any other Sickness for the treatment and correction of cleft lip and cleft palate, including secondary conditions and treatment attributable to the primary condition of cleft lip and cleft palate.

Benefits include, but are not limited to, the following:
- Oral and facial surgery, surgical management, and follow-up care.
- Prosthetic treatment such as obturators, speech appliances, and feeding appliances.
- Orthodontic treatment and management.
- Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management or therapy.
- Speech-language evaluation and therapy.
- Audiological assessments and amplification devices.
- Otolaryngology treatment and management.
- Psychological assessment and counseling.
- Genetic assessment and counseling for patient and parents.

46. **Genetic Testing.**
Benefits are limited to genetic testing when the results are specifically required for a medical treatment decision or when required by law.

47. **Hearing Aids.**
Hearing aids for Insured Persons age 17 and under when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician.

If more than one type of hearing aid can meet the Insured's functional needs, benefits are available only for the hearing aid that meets the minimum specifications for the Insured’s needs. Benefits are limited to one hearing aid per hearing impaired ear every 36 months.

48. **Interpreter Expenses.**
Services of an interpreter/transliterator, other than a family member of the Insured, when such services are used by the Insured in connection with Covered Medical Expenses performed by a Physician.

49. **Medical Foods.**
Low Protein Food Products for the treatment of Inherited Metabolic Diseases.

For the purpose of this benefit:
- Low Protein Food Product means a food product that is especially formulated to have less than one gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low Protein Food Products shall not include a natural food that is naturally low in protein.
- Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry. Such diseases shall be limited to Phenylketonuria (PKU), Maple Syrup Urine Disease (MSUD), Methylmalonic Acidemia (MMA), Isovaleric Acidemia (IVA) Propionic Acidemia, Glutaric Acidemia, Urea Cycle Defects, and Tyrosinemia.

50. **Medical Supplies.**
Disposable medical equipment and supplies which have a primary medical purpose and meet all of the following criteria:
- Related to and necessary for the administration of Prescription Drugs, such as syringes and needles.
- 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.

51. **Sleep Disorders.**
Benefits are limited to Medically Necessary sleep studies and associated professional services when a sleep study is obtained in a facility accredited by the Joint Commission or the American Academy of Sleep Medicine.

Section 7: Mandated Benefits

**BENEFITS FOR MAMMOGRAPHY**

Benefits will be provided for a mammogram subject to the following guidelines:

1. One baseline mammogram examination for a woman who is thirty-five through thirty-nine years of age.
2. One mammogram examination every one to two years, or more frequently if recommended by a Physician, for a woman who is forty through forty-nine years of age.
3. One mammogram every 12 months for a woman who is age fifty and over.

Mammography covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Mammography not covered by the Preventive Care Services Benefit shall be covered under this benefit and shall not be subject to the policy Deductible, but shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the Policy.

**BENEFITS FOR PAP SMEAR**

Benefits will be provided for an annual Pap Smear.

Pap Smears covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Pap Smears not covered by the Preventive Care Services benefit shall be covered under this benefit and shall not be subject to the policy Deductible, but shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the Policy.

**BENEFITS FOR DETECTION OF PROSTATE CANCER**

Benefits will be provided for expenses incurred for Routine Prostate Preventive Care for the detection of prostate cancer, including digital rectal examinations and prostate-specific antigen testing as follows:

1. Annually for men over the age of fifty.
2. As Medically Necessary and appropriate for men over the age of forty.

“Routine Prostate Preventive Care” means a minimum of one routine annual visit, provided that a second visit shall be permitted based upon Medical Necessity and follow-up treatment within sixty days after either visit if related to a condition diagnosed or treated during the visits.

Routine Prostate Preventive Care covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Routine Prostate Preventive Care not covered by the Preventive Care Services benefit shall be covered under this benefit and shall not be subject to the policy Deductible, but shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the Policy.

**BENEFITS FOR ROUTINE COLORECTAL CANCER SCREENING**

Benefits will be provided for Routine Colorectal Cancer Screening.
“Routine Colorectal Cancer Screening” shall mean a fecal immunochemical test for blood, flexible sigmoidoscopy, or colonoscopy provided in accordance with that most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced below:

1. Colonoscopy every ten years beginning at age 50 (or age 45 for African Americans).
2. Flexible sigmoidoscopy every five to ten years.
3. Annual FIT (fecal immunochemical test) for blood.

“Routine Colorectal Cancer Screening” shall not mean services otherwise excluded from coverage because they are deemed by the Company to be experimental or investigational.

Routine Colorectal Cancer Screening covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Routine Colorectal Cancer Screening not covered by the Preventive Care Services benefit shall be covered under this benefit and shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

**BENEFITS FOR OSTEOPOROSIS SCREENING**

Benefits will be provided for a Qualified Insured for Bone Mass Measurement for the diagnosis and treatment of osteoporosis.

For the purpose of this benefit, the following definitions shall apply:

1. "Bone mass measurement" means a radiologic or radioisotopic procedure or other scientifically proven technologies performed on an individual for the purpose of identifying bone mass or detecting bone loss.
2. "Qualified Insured" means: (a) An estrogen deficient woman at clinical risk of osteoporosis who is considering treatment. (b) An individual receiving long term steroid therapy. (c) An individual being monitored to assess to response to or efficacy of approved osteoporosis drug therapies.

Bone Mass Measurement covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Bone Mass Measurement not covered by the Preventive Care Services benefit shall be covered under this benefit and shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

**BENEFITS FOR PROSTHETIC DEVICES AND PROSTHETIC SERVICES**

Benefits will be paid the same as any other Sickness for Medically Necessary Prosthetic Devices provided by an accredited facility and Prosthetic Services prescribed by a Physician and provided by an accredited facility. The Medical Necessity determination shall be based on information and recommendation from the treating Physician in consultation with the Insured, including the result of a functional limit test. The functional limit test shall consider, but not be limited to, the following factors:

1. The Insured’s past history, including prior use of Prosthetic Devices, if applicable.
2. The Insured’s current condition, including the status of the residual limb and the nature of other medical problems.
3. The Insured’s desire to ambulate, with respect to lower limb prosthetic devices, or maximum upper limb function, with respect to upper limb prosthetic devices.

An “accredited facility” means any entity that is accredited by the American Board for Certification in Orthotics, Prosthetics, and Pedorthotics or by the Board for Orthotist/Prosthetist Certification and that provides prosthetic devices or prosthetic services.

“Prosthetic device” or “prosthesis” means an artificial limb designed to maximize function, stability, and safety of the patient. Prosthetic device or prosthesis also means an artificial medical device that is not surgically implanted and that is used to replace a missing limb. The term does not include artificial eyes, ears, noses, dental appliances, ostomy products, or devices such as eyelashes or wigs.
“Prosthetic services” means the science and practice of evaluating, measuring, designing, fabricating, assembling, fitting, aligning, adjusting, or servicing of a prosthesis through the replacement of external parts of a human body lost due to amputation or congenital deformities to restore function, cosmesis, or both. Prosthetic services shall also include any Medically Necessary clinical care.

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

**BENEFITS FOR THE TREATMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER**

Benefits will be paid the same as any other Sickness for the diagnosis and treatment for attention deficit/hyperactivity disorder (ADHD) when rendered or prescribed by a Physician or other appropriate health care provider and received in any Physician’s or other health care provider’s office, any licensed Hospital, or in any other licensed public or private facility, or portion thereof, including but not limited to clinics and mobile screening units.

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

**BENEFITS FOR THE DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS**

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

“Autism spectrum disorders” means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including but not limited to, Autistic Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

“Diagnosis of autism spectrum disorders” means medically necessary assessment, evaluations, or tests to diagnose whether an Insured has one of the autism spectrum disorders.

*Treatment of autism spectrum disorders* shall include the following care prescribed, provided, or ordered for an Insured diagnosed with one of the autism spectrum disorders by a Physician or psychologist:

1. Habilitative or rehabilitative care – professional, counseling, and guidance services and treatment program, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an Insured.
2. Pharmacy care – medications prescribed by a licensed Physician.
3. Psychiatric care – direct or consultative services provided by a licensed psychiatrist.
4. Psychological care - direct or consultative services provided by a licensed psychologist.
5. Therapeutic care – services provided by a licensed or certified speech therapist, occupational therapist, or physical therapist.

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

**BENEFITS FOR LYMPHEDEMA**

Benefits will be paid the same as any other Sickness for the treatment of lymphedema, including multilayer compression bandaging systems and custom or standard-fit gradient compression garments.

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

**BENEFITS RELATED TO A SEXUALLY-ORIENTED CRIMINAL OFFENSE**

Benefits shall be provided for services rendered in conducting a forensic medical examination and shall include, but not be limited to, the following services directly related to the forensic examination:

1. Forensic examiner and Hospital or healthcare facility services, including integral forensic supplies.
2. Scope procedures, including but not limited to anoscopy and colposcopy.
3. Laboratory testing, including drug screening, urinalysis, pregnancy screening, syphilis screening, chlamydia culture, gonorrhea culture, blood test for HIV screening, hepatitis B and C screening, herpes culture, and any other sexually transmitted disease testing.
4. Any medication provided during the exam.

“Forensic medical examination” means an examination provided to a victim of a sexually-oriented criminal offense. The examination shall be conducted by a health care provider for the purpose of gathering and preserving evidence of a sexual assault for use in a court of law. A forensic medical examination shall include the following:

1. Examination of physical trauma.
2. Patient interview, including medical history, triage, and consultation.
3. Collection and evaluation of evidence, including but not limited to:
   a. Photographic documentation.
   b. Preservation and maintenance of chain of custody.
   c. Medical specimen collection.
   d. When necessary, an alcohol and drug facilitated sexual assault assessment and toxicology screening.

A claims related to a sexually-oriented criminal offense shall be submitted to the Company with the Insured victim’s consent.

Upon receipt of a claim related to a sexually-oriented criminal offense, the Company shall:

1. Allow the Insured victim to designate any address to be used for the purposes of transmitting an explanation of benefits.
2. Allow the Insured victim to designate that no explanation of benefits be generated or transmitted.

The Company shall waive all applicable Deductible, Copayment, and Coinsurance provisions of the Policy for any claim related to a sexually-oriented criminal offense.

Section 8: Excess Provision

Even if you have other insurance, the plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid.

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first $100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with Policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other group insurance does not cover the loss.

Section 9: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight
If such Injury shall independently of all other causes and within 90 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or Beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of
   Life $ 5,000
   Two or More Members $ 5,000
   One Member $ 2,500
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: Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student policy for at least 6 consecutive months and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

Application must be made and premium must be paid directly to UnitedHealthcare StudentResources and be received within 30 days after the expiration date of the Insured's coverage. For further information on the Continuation Privilege, please contact UnitedHealthcare StudentResources.

Section 11: Definitions

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

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

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

BENEFICIARY means a person designated by an Insured Person, or by the terms of a health insurance benefit plan, who is or may become entitled to a benefit under the plan.

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

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**DAY REHABILITATION PROGRAM** means a program that provides greater than one (1) hour of rehabilitative services upon discharge from an Inpatient confinement.

**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.

**DEPENDENT** means the legal spouse or Domestic Partner of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

Dependent shall also mean a grandchild until the age of 26 who is in the legal custody of and residing with the grandparent who is the Named Insured.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child:

1. Is incapable of self-sustaining employment by reason of intellectual or physical disability.
2. Became so incapable prior to the attainment of age 26.
3. Is chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually after the two year period following the child's attainment of the limiting age.

If a claim is denied under the Policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be intellectually or physically disabled as defined by subsections (1) and (2).

**DOMESTIC PARTNER** means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other's welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

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

**EMERGENCY SERVICES** means with respect to a Medical Emergency:

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

**HABILITATIVE SERVICES** means health care services and devices that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, and other services for people with disabilities.
Habilitative services do not include Elective Surgery or Elective Treatment or services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

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

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

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

**INJURY** means bodily injury which is all of the following:

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

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

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

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

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

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

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

**MEDICAL EMERGENCY** means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

**MEDICAL NECESSITY/MEDICALLY NECESSARY** means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1. Essential for the symptoms and diagnosis or treatment of the Sickness or Injury.
2. Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury.
3. In accordance with the standards of good medical practice.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.
5. The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both:

1. The Insured requires acute care as a bed patient.
2. The Insured cannot receive safe and adequate care as an outpatient.

No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

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

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

**NEWBORN INFANT** means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 31 days after birth or date of discharge, whichever is later. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child’s parent.

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

In addition, an Insured Person shall be authorized to add a newborn child to this coverage at any time prior to the child’s birth to be effective upon the date of the child’s birth. Such coverage shall be subject to payment of the required additional premium, if any, for the child’s coverage.

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

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

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

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

**POLICY OR MASTER POLICY** means the entire agreement issued to the Policyholder that includes all of the following:
1. The Policy.
2. The Policyholder Application.
4. The Schedule of Benefits.
5. 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.

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

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

**RESIDENTIAL TREATMENT CENTER** means a twenty-four (24) hour, non-acute care treatment setting for the active treatment of specific impairments of Mental Illness or Substance Use Disorder.

**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 where the major portion of the individual tooth is present and includes those which are capped, crowned or attached by way of a crown or cap to a bridge. Sound, natural teeth may have fillings or root canals but may not be 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 the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.

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

**USUAL AND CUSTOMARY CHARGES** means the maximum amount the Policy is obligated to pay for services. Except as otherwise required under state or federal regulations, usual and customary charges will be the lowest of:

1. The billed charge for the services.
2. An amount determined using current publicly-available data which is usual and customary when compared with the charges made for a) similar services and supplies and b) to persons having similar medical conditions in the geographic area where service is rendered.
3. An amount determined using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical difference where applicable, plus a margin factor.

The Company uses data from FAIR Health, Inc. and/or Data iSight to determine Usual and Customary Charges. No payment will be made under the Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

**Section 12: 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.
5. 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.
   - Treat or correct a Congenital Condition existing at or from birth which significantly interferes with normal bodily function, such as cleft lip and cleft palate.
6. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
7. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As described under Dental Treatment and Oral Surgery in the Policy.
   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
10. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
11. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).
   This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
12. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.
   - An implantable bone conduction hearing aid.
   - Hearing aids for Insureds age 17 and under as specifically provided in the Policy.
14. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
15. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
16. Injury sustained while:
   - Participating in any intercollegiate or professional sport, contest or competition.
   - Traveling to or from such sport, contest or competition as a participant.
   - Participating in any practice or conditioning program for such sport, contest or competition.
17. Investigational services.
18. Liptectomy.
19. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.
20. Prescription Drugs, services or supplies as follows:
   - Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
   - Immunization agents, except as specifically provided in the Policy.
   - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
   - Products used for cosmetic purposes.
   - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
   - Anorectics - drugs used for the purpose of weight control.
   - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
• Growth hormones, except for chronic renal insufficiency, AIDS wasting, Turner’s Syndrome, and growth hormone deficiency with abnormal provocative stimulation testing.
• Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

21. Reproductive/Infertility services including but not limited to the following:
• Procreative counseling.
• Genetic counseling and genetic testing.
• Cryopreservation of reproductive materials. Storage of reproductive materials.
• Fertility tests.
• Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
• Premarital examinations.
• Impotence, organic or otherwise.
• Reversal of sterilization procedures.

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

23. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems. This exclusion does not apply as follows:
• When due to a covered Injury or disease process.
• To benefits specifically provided in Pediatric Vision Services.
• To the initial fitting and one pair of eyeglasses or contact lenses required following cataract surgery.

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

25. Preventive care services which are not specifically provided in the Policy, including:
• Routine physical examinations and routine testing.
• Preventive testing or treatment.
• Screening exams or testing in the absence of Injury or Sickness.

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

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


29. Sleep disorders, except as specifically provided in the Policy.

30. Speech therapy, except as specifically provided in the Policy.

31. Supplies, except as specifically provided in the Policy.

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

33. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
• Motorcycle.
• 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.

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

35. 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).

36. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

Section 13: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 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.

Submit the above information to the Company by mail:

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

Section 14: General Provisions

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

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

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

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

When an Out-of-Network Provider files a claim for Covered Medical Expenses for services related to a Medical Emergency, the Company shall reimburse the Out-of-Network Provider directly. Under no circumstances shall such payment be made directly to the Insured Person.

Non-electronic Claims: Upon receipt of due written proof of loss submitted by a provider within 45 days of the date of service or date of discharge, the Company shall have 45 working days to pay, deny, or pend the claim. If due written proof of loss is submitted by a provider more than 45 days after the date of service or date of discharge, the Company shall have 60 working days to pay, deny, or pend the claim. Any written proof of loss submitted by an Insured shall be paid, denied, or pended within 45 working days from the date the Company receives the clean claim. These time limits do not apply if the claim could not be processed due to just and reasonable grounds which require the Company to investigate the claim further.

Electronic Claims: Upon receipt of due electronic proof of loss, the Company shall have 25 working days to pay, deny, or pend the claim. If due written proof of loss is submitted by a provider more than 45 days after the date of service or date of discharge, the Company shall have 60 working days to pay, deny, or pend the claim. Any written proof of loss submitted by an Insured shall be paid, denied, or pended within 45 working days from the date the Company receives the clean claim. These time limits do not apply if the claim could not be processed due to just and reasonable grounds which require the Company to investigate the claim further.

For any claim that is pended, the Company shall provide either written notice of the pendency or allow the provider internet access to such information.

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 one year after the time written proofs of loss are required to be furnished.

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured will be made whole or fully compensated before the Company subrogates. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company. The Company will pay its portion of the Insured’s attorneys’ fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid pursuant to this provision.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear. The Company will pay its portion of the Insured's attorneys’ fees or other costs associated with a claim or lawsuit to the extent that the Company recovers any portion of the benefits paid under this policy pursuant to this provision.

The Company has the right to reduce, offset, adjust, or lower the payment of a claim or any other amount owed to a health care provider for any reason unrelated to that claim or amount owed to the provider. Prior to any recoupment unrelated to a claim for payment of Covered Medical Services, the Company shall provide the provider with written notification that includes the name of the Insured, the dates of service, and an explanation of the reason for recoupment. The provider has thirty days from receipt of the notification to submit a written appeal the recoupment action. If no written appeal is submitted, the Company shall consider the recoupment accepted. If a recoupment is accepted, the provider may remit the agreed amount to the Company at the time of any written notification of acceptance or the provider may indicate that the Company shall deduct the agreed upon amount from future payments due.

If a provider disputes the Company’s written notification of recoupment and a contract exists between the provider and the Company, the dispute shall be resolved according to the general dispute resolution provisions in the contract. If no contract exists between the provider and the Company, the dispute shall be resolved as any other dispute under Civil Code Article 2299 et seq. If the recoupment directly affects the payment responsibility of the Insured, the Company shall provide a revised explanation of benefits to the provider and the Insured for whose claim the recoupment is being made. Unless the recoupment of a claim payment directly affects the payment responsibility of the Insured, the recoupment shall not result in any increased liability of the Insured.

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 15: 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 StudentResources, PO Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process

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

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

Within 3 working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:
1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person’s request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, 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.
2. 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 that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company’s original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company’s standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person’s benefit request;
   d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
   e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;

5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State’s External Review legislation;

6. The Insured Person’s right to bring a civil action in a court of competent jurisdiction; and

7. Notice of the Insured Person’s right to contact the commissioner’s office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner’s office.

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 seventy-two (72) hours after the Company’s receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care 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 the 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. If the notice is provided orally, then the Company shall provide a written or electronic version of the notice within 3 days following the oral notice.

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 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Company. Upon request of an External Review, the Company shall notify the Commissioner of the request within 1 business day.

Where to Send External Review Requests
All types of External Review requests shall be submitted to Claims Appeals at the following address:

Claims Appeals
UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, TX 75380-9025
1-888-315-0447

Standard External Review (SER) Process
A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company’s Adverse Determination or Final Adverse Determination.

1. Within 5 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 5 business days 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.
   c. If the request is not eligible, the Insured Person or the Authorized Representative may submit a written request for reconsideration to the Commissioner. The Commissioner may determine that a request is eligible for external review and require that it be referred for external review.
   d. If the Commissioner determines that a request is eligible for external review, the Commissioner shall notify the Company and the Insured Person or the Authorized Representative within 5 business days.

3. After determining that a request is eligible for SER or after receiving notice from the Commissioner that a request is eligible for SER, the Company shall, within 1 business day, input a request for an assignment of an Independent Review Organization (IRO) through the Departments of Insurance website.

4. Upon notification through the website, the Commissioner shall:
   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 5 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 5 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 1 business day, 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 1 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 1 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.

8. 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 Company at the time the Insured Person receives:
   a. An Adverse Determination if:
      • The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      • The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
   b. A Final Adverse Determination, if:
      • The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
      • The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

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

2. Upon receipt of an EER request, the Company shall send a copy of the request to the Commissioner within 1 business day.

3. Upon receipt of a request for an EER, the Company shall immediately review the request to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. The Insured Person has exhausted the Company’s Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
   c. The Insured Person has provided all the information and forms necessary to process the request; and
   d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

4. Immediately after completion of the review, the Company shall notify the 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.

c. If the request is not eligible, the Insured Person or the Authorized Representative may submit a written request for reconsideration to the Commissioner. The Commissioner may determine that a request is eligible for external review and require that it be referred for external review.

d. If the Commissioner determines that a request is eligible for external review, the the Commissioner shall immediately notify the Company and the Insured Person or the Authorized Representative.

5. After determining that a request is eligible for EER or after receiving notice from the Commissioner that a request is eligible for EER, the Company shall immediately input a request for assignment of a IRO through the Department of Insurance website.

6. Upon notification through the website, 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.

7. 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.

8. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
   a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
   b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.

9. 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.

**Experimental or Investigational Treatment External Review (EIER) 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 an Experimental or Investigational External Review must be submitted in writing within 4 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 an Experimental or Investigational Treatment External Review (EIER) with the Company.

2. Within 5 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 5 business days 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 EIER.
   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.
   c. If the request is not eligible, the Insured Person or the Authorized Representative may submit a written request for reconsideration to the Commissioner. The Commissioner may determine that a request is eligible for external review and require that it be referred for external review.
   d. If the Commissioner determines that a request is eligible for external review, the Commissioner shall notify the Company and the Insured Person or the Authorized Representative within 5 business days.

4. After determining that a request is eligible for EIER or after receiving notice from the Commissioner that a request is eligible for EIER, the Company shall, within 1 business day, input a request for an assignment of any IRO through the Department of Insurance website.

5. Upon notification through the website, the Commissioner shall:
   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 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

6. a. The Company shall, within 5 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 EIER.
   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.

7. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.

8. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 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 EIER.
   b. The EIER 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 EIER.
   c. If the Company reverses it 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 EIER.

9. 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.

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:
1. A determination by the Company that, based upon the information provided, a request for benefits under the Policy does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental or investigational, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company’s determination that the individual was not eligible for coverage under the Policy as an Insured Person;
3. Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy; or
4. A rescission of coverage.

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

**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, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

**Questions Regarding Appeal Rights**
Contact Customer Service at 1-800-767-0700 with questions regarding the Insured Person’s rights to an Internal Appeal and External Review.
Other resources are available to help the Insured Person navigate the appeals process. The State of Louisiana Department of Insurance is available to assist insurance consumers with insurance-related problems and questions. You may inquire in writing at:

Louisiana Department of Insurance
1702 North Third Street
Baton Rouge, LA 70802
(800) 259-5300
(225) 342-5900
Website: www.ldi.state.la.us

Section 16: Online Access to Account Information

UnitedHealthcare Student Resources Insureds have online access to claims status, EOBs, ID cards, network providers, correspondence, and coverage information by logging in to My Account at www.uhcsr.com/myaccount. Insured students who don’t already have an online account may simply select the “create My Account Now” 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 Message Center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. In Message Center, notifications are securely sent directly to the Insured student’s email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Email Preferences and making the change there.

Section 17: ID Cards

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

Section 18: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating healthcare or Mental Health providers, 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 both the primary Insured and covered Dependents; includes provider, date of service, status, claim amount and amount paid.

Section 19: Important Company Contact Information

The Policy is Underwritten by:

UNITEDHEALTHCARE INSURANCE COMPANY

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

Sales/Marketing Services:
UnitedHealthcare Student Resources
Section 20: Pediatric Dental Services Benefits

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

Covered Dental Services shall include all federally required pediatric dental benefits outlined under the 2014 FEDVIP Dental Plan. The FEDVIP Dental Plan can be found at: http://archive.opm.gov/insure/health/planinfo/2014/brochures/MetLife.pdf.

Section 1: Accessing Pediatric Dental Services

Network and Non-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 a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

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

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

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

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

Covered Dental Services

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

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

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.

**Pre-Authorization**

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

**Section 2: Benefits for Pediatric Dental Services**

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

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

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

**Network Benefits:**

Benefits for Eligible Dental Expenses 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.

**Non-Network Benefits:**

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

**Dental Services Deductible**

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

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

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

**Benefits**

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

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

**Benefit Description**

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Services</strong> (Subject to payment of the Dental Services Deductible.)</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td><em>Evaluations (Checkup Exams)</em></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 2 times per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered as a separate benefit only if no other service was done during the visit other than X-rays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0120 - Periodic oral evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0140 - Limited oral evaluation - problem focused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0150 - Comprehensive oral evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0180 - Comprehensive periodontal evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0160 - Detailed and extensive oral evaluation - problem focused</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intraoral Radiographs (X-ray)</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 2 series of films per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0210 - Complete series (including bitewings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0220 - Intraoral - periapical first film</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0230 - Intraoral - periapical - each additional film</td>
<td></td>
<td></td>
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<tr>
<td>D0240 - Intraoral - occlusal film</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any combination of the following services is limited to 2 series of films per 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0270 - Bitewings - single film</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0272 - Bitewings - two films</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0274 - Bitewings - four films</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0277 - Vertical bitewings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 1 time per 36 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0330 - Panoramic radiograph image</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>-------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>D0340 - Cephalometric X-ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0350 - Oral/Facial photographic images</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0391 - Interpretation of diagnostic images</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0470 - Diagnostic casts</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Services- (Subject to payment of the Dental Services Deductible.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Prophylaxis (Cleanings)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are limited to 2 times every 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D1110 - Prophylaxis - adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1120 - Prophylaxis - child</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fluoride Treatments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are limited to 2 times every 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D1206 and D1208 - Fluoride</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sealants (Protective Coating)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are limited to once per first or second permanent molar every 36 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D1351 - Sealant - per tooth - unrestored permanent molar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Space Maintainers (Spacers)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D1510 - Space maintainer - fixed - unilateral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1515 - Space maintainer - fixed - bilateral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1520 - Space maintainer - removable - unilateral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1525 Space maintainer - removable bilateral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1550 - Re-cementation of space maintainer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Minor Restorative Services- (Subject to payment of the Dental Services Deductible.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Amalgam Restorations (Silver Fillings)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D2140 - Amalgams - one surface, primary or permanent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2150 - Amalgams - two surfaces,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Composite Resin Restorations (Tooth Colored Fillings)</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crowns/Inlays/Onlays- (Subject to payment of the Dental Services Deductible.)</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following services are subject to a limit of 1 time every 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2510 Inlay - metallic - one surface</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2520 Inlay - metallic - two surfaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2530 Inlay - metallic - three surfaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2910 - Re-cement inlay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2920 - Re-cement crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D2940 - Protective restoration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is limited to 1 time per tooth every 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D2950 - Core buildup, including any pins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is limited to 1 time per tooth every 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D2951 - Pin retention - per tooth, in addition to Crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D2954 - Prefabricated post and core in addition to crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D2980 - Crown repair necessitated by restorative material failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2981 - Inlay repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2982 - Onlay repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2983 - Veneer repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2990 - Resin infiltration/smooth surface</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics- (Subject to payment of the Dental Services Deductible.)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3220 - Therapeutic pulpotomy (excluding final restoration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
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<td>-------------------------------------</td>
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</tr>
<tr>
<td>(excluding final restoration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3310 - Anterior root canal (excluding final restoration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3320 - Bicuspid root canal (excluding final restoration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3330 - Molar root canal (excluding final restoration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3346 - Retreatment of previous root canal therapy - anterior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3347 - Retreatment of previous root canal therapy - bicuspid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3348 - Retreatment of previous root canal therapy - molar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3351 - Apexification/recalcification - initial visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3352 - Apexification/recalcification - interim medication replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3353 - Apexification/recalcification - final visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3354 - Pulpal Regeneration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3410 - Apicoectomy/periradicular - anterior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3421 - Apicoectomy/periradicular - bicuspid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3425 - Apicoectomy/periradicular - molar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3426 - Apicoectomy/periradicular - each additional root</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3450 - Root amputation - per root</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3920 - Hemisection (including any root removal), not including root canal therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Periodontics- (Subject to payment of the Dental Services Deductible.)
<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses</th>
<th>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The following services are limited to a frequency of 1 every 36 months.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4210 - Gingivectomy or gingivoplasty - four or more teeth</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4211 - Gingivectomy or gingivoplasty - one to three teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4212 - Gingivectomy or gingivoplasty – with restorative procedures – per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to 1 every 36 months.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4240 - Gingival flap procedure, four or more teeth</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following service is not subject to a frequency limit.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4249 - Clinical crown lengthening - hard tissue</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>The following services are limited to 1 every 36 months.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4260 - Osseous surgery</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4263 - Bone replacement graft – first site in quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4270 - Pedicle soft tissue graft procedure</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4271 - Free soft tissue graft procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4273 - Subepithelial connective tissue graft procedures, per tooth</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4275 - Soft tissue allograft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4277 - Free soft tissue graft - first tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4278 - Free soft tissue graft - additional teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to 1 time per quadrant every 24 months.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4341 - Periodontal scaling and root</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following service is limited to a frequency to 1 per lifetime. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Removable Dentures - (Subject to payment of the Dental Services Deductible.)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base D5212 - Maxillary partial denture - resin base D5213 - Maxillary partial denture - cast metal framework with resin denture base D5214 - Mandibular partial denture - cast metal framework with resin denture base D5281 - Removable unilateral partial denture - one piece cast metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>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 D5510 - Repair broken complete denture base D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5620 - Repair cast framework</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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</tr>
<tr>
<td><strong>Benefit Description and Limitations</strong></td>
<td><strong>Network Benefits</strong></td>
<td><strong>Non-Network Benefits</strong></td>
</tr>
<tr>
<td><strong>Benefits are shown as a percentage of Eligible Dental Expenses.</strong></td>
<td><strong>Benefits are shown as a percentage of Eligible Dental Expenses.</strong></td>
<td></td>
</tr>
<tr>
<td>D5630 - Repair or replace broken clasp</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D5640 - Replace broken teeth - per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5650 - Add tooth to existing partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5660 - Add clasp to existing partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months.</strong></td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D5710 - Rebase complete maxillary denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5720 - Rebase maxillary partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5721 - Rebase mandibular partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5730 - Reline complete maxillary denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5731 - Reline complete mandibular denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5740 - Reline maxillary partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5741 - Reline mandibular partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5750 - Reline complete maxillary denture (laboratory)</td>
<td></td>
<td></td>
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<tr>
<td>D5751 - Reline complete mandibular denture (laboratory)</td>
<td></td>
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</tr>
<tr>
<td>D5752 - Reline complete mandibular denture (laboratory)</td>
<td></td>
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<tr>
<td>D5760 - Reline maxillary partial denture (laboratory)</td>
<td></td>
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<tr>
<td>D5761 - Reline mandibular partial denture (laboratory) - relase/reline</td>
<td></td>
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<tr>
<td>D5762 - Reline mandibular partial denture (laboratory)</td>
<td></td>
<td></td>
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<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D5850 - Tissue conditioning (maxillary)</td>
<td></td>
<td></td>
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<tr>
<td>D5851 - Tissue conditioning (mandibular)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6210 - Pontic - case high noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6211 - Pontic - case predominately base metal</td>
<td></td>
<td></td>
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<tr>
<td>D6212 - Pontic - cast noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6214 - Pontic - titanium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6240 - Pontic - porcelain fused to high noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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</tr>
<tr>
<td>Benefit are shown as a percentage of Eligible Dental Expenses.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6241 - Pontic - porcelain fused to predominately base metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6242 - Pontic - porcelain fused to noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6245 - Pontic - porcelain/ceramic</td>
<td></td>
<td></td>
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<tr>
<td>The following services are not subject to a frequency limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6545 - Retainer - cast metal for resin bonded fixed prosthesis</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis</td>
<td></td>
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<tr>
<td>The following services are not subject to a frequency limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6519 - Inlay/onlay - porcelain/ceramic</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6520 - Inlay - metallic - two surfaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6530 - Inlay - metallic - three or more surfaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6543 - Onlay - metallic - three surfaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6544 - Onlay - metallic - four or more surfaces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are limited to 1 time every 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6740 - Crown - porcelain/ceramic</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6750 - Crown - porcelain fused to high noble metal</td>
<td></td>
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<tr>
<td>D6751 - Crown - porcelain fused to predominately base metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6752 - Crown - porcelain fused to noble metal</td>
<td></td>
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<tr>
<td>D6780 - Crown - 3/4 cast high noble metal</td>
<td></td>
<td></td>
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<tr>
<td>D6781 - Crown - 3/4 cast predominately base metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6782 - Crown - 3/4 cast noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6783 - Crown - 3/4 porcelain/ceramic</td>
<td></td>
<td></td>
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<tr>
<td>D6790 - Crown - full cast high noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6791 - Crown - full cast predominately base metal</td>
<td></td>
<td></td>
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<tr>
<td>D6792 - Crown - full cast noble metal</td>
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<td></td>
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<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6930 - Re-cement or re-bond fixed partial denture</td>
<td></td>
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<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6973 - Core build up for retainer, including any pins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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<td>----------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Benefit are shown as a percentage of Eligible Dental Expenses.</td>
<td></td>
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<tr>
<td>D6980 - Fixed partial denture repair necessitated by restorative material failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery- (Subject to payment of the Dental Services Deductible.)</td>
<td></td>
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<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7140 - Extraction, erupted tooth or exposed root</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7220 - Removal of impacted tooth - soft tissue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7230 - Removal of impacted tooth - partially bony</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7240 - Removal of impacted tooth - completely bony</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7241 - Removal of impacted tooth - complete bony with unusual surgical complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7250 - Surgical removal or residual tooth roots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7251 - Coronectomy - intentional partial tooth removal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td></td>
<td></td>
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<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7280 - Surgical access of an unerupted tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7310 - Alveoloplasty in conjunction with extractions - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7320 - Alveoloplasty not in conjunction with extractions - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Network Benefits</strong></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7471 - removal of lateral exostosis (maxilla or mandible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7510 - Incision and drainage of abscess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7910 - Suture of recent small wounds up to 5 cm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7921 - Collect - apply autologous product</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7953 - Bone replacement graft for ridge preservation - per site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7971 - Excision of pericoronal gingiva</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adjunctive Services- (Subject to payment of the Dental Services Deductible.)</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Covered only when clinically Necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9110 - Palliative (Emergency) treatment of dental pain - minor procedure</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Covered only when clinically Necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9220 - Deep sedation/general anesthesia first 30 minutes</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D9221 - Dental sedation/general anesthesia each additional 15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9241 - Intravenous conscious sedation/analgesia - first 30 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9610 - Therapeutic drug injection, by report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered only when clinically Necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following is limited to 1 guard every 12 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D9940 - Occlusal guard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Procedures- (Subject to payment of the Dental Services Deductible.)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following services are limited to 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9940 - Occlusal guard</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Network Benefits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td></td>
</tr>
</tbody>
</table>

*Time every 60 months.*

D6010 - Endosteal implant
D6012 - Surgical placement of interim implant body
D6040 - Eposteal Implant
D6050 - Transosteal implant, including hardware
D6053 - Implant supported complete denture
D6054 - Implant supported partial denture
D6055 - Connecting bar implant or abutment supported
D6056 - Prefabricated abutment
D6057 - Custom abutment
D6058 - Abutment supported porcelain ceramic crown
D6059 - Abutment supported porcelain fused to high noble metal
D6060 - Abutment supported porcelain fused to predominately base metal crown
D6061 - Abutment supported porcelain fused to noble metal crown
D6062 - Abutment supported cast high noble metal crown
D6063 - Abutment supported case predominately base metal crown
D6064 - Abutment supported porcelain/ceramic crown
D6065 - Implant supported porcelain/ceramic crown
D6066 - Implant supported porcelain fused to high metal crown
D6067 - Implant supported metal crown
D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture
D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture
D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture
D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture
D6072 - Abutment supported retainer for cast high noble metal fixed partial denture
D6073 - Abutment supported retainer for predominately base metal fixed partial denture
### Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Benefit Code</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6074</td>
<td>Abutment supported retainer for cast metal fixed partial denture</td>
</tr>
<tr>
<td>D6075</td>
<td>Implant supported retainer for ceramic fixed partial denture</td>
</tr>
<tr>
<td>D6076</td>
<td>Implant supported retainer for porcelain fused to high noble metal fixed partial denture</td>
</tr>
<tr>
<td>D6077</td>
<td>Implant supported retainer for cast metal fixed partial denture</td>
</tr>
<tr>
<td>D6078</td>
<td>Implant/abutment supported fixed partial denture for completely edentulous arch</td>
</tr>
<tr>
<td>D6079</td>
<td>Implant/abutment supported fixed partial denture for partially edentulous arch</td>
</tr>
<tr>
<td>D6080</td>
<td>Implant maintenance procedure</td>
</tr>
<tr>
<td>D6090</td>
<td>Repair implant prosthesis</td>
</tr>
<tr>
<td>D6091</td>
<td>Replacement of semi-precision or precision attachment</td>
</tr>
<tr>
<td>D6095</td>
<td>Repair implant abutment</td>
</tr>
<tr>
<td>D6100</td>
<td>Implant removal</td>
</tr>
<tr>
<td>D6101</td>
<td>Debridement perimplant defect</td>
</tr>
<tr>
<td>D6102</td>
<td>Debridement and osseous periimplant defect</td>
</tr>
<tr>
<td>D6103</td>
<td>Bone graft periimplant defect</td>
</tr>
<tr>
<td>D6104</td>
<td>Bone graft implant replacement</td>
</tr>
<tr>
<td>D6190</td>
<td>Implant index</td>
</tr>
</tbody>
</table>

### Network Benefits

Benefits are shown as a percentage of Eligible Dental Expenses.

### Non-Network Benefits

Benefits are shown as a percentage of Eligible Dental Expenses.

### Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)

Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon’s syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company’s dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be prior authorized.

Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.

The following services are not subject to a frequency limitation as long as benefits have been prior authorized.

<table>
<thead>
<tr>
<th>Benefit Code</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8010</td>
<td>Limited orthodontic treatment of the primary dentition</td>
</tr>
<tr>
<td>D8020</td>
<td>Limited orthodontic treatment of the transitional dentition</td>
</tr>
<tr>
<td>D8030</td>
<td>Limited orthodontic treatment of the adolescent dentition</td>
</tr>
<tr>
<td>D8050</td>
<td>Interceptive orthodontic</td>
</tr>
</tbody>
</table>

| | 50% | 50% |
### Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of the primary dentition</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>D8060 - Interceptive orthodontic treatment of the transitional dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8070 - Comprehensive orthodontic treatment of the transitional dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8080 - Comprehensive orthodontic treatment of the adolescent dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8210 - Removable appliance therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8220 - Fixed appliance therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8660 - Pre-orthodontic treatment visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8670 - Periodic orthodontic treatment visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8680 - Orthodontic retention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this section 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 regimenes not accepted by the [American Dental Association (ADA) Council on Dental Therapeutics](https://www.ada.org/porel). The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this section to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person’s family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction, except for cleft lip/cleft palate.

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 a non-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 1-877-816-3596. This number is also 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:

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

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

**Dental Provider** - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.
Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Insured Person while the Policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

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

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

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

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

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

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

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

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

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

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

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

Non-Network Benefits - benefits available for Covered Dental Services obtained from Non-Network Dentists.
Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

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

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

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

Section 21: Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

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

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

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

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

Benefit Description
Benefits

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

**Frequency of Service Limits**

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

**Routine Vision Examination**

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

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

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

**Eyeglass Lenses**

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

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

If the Insured Person purchases *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks 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 select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If the Insured Person selects more than one of these Vision Care Services, the Company will pay benefits for only one Vision Care Service.

If the Insured Person purchases *Eyeglass Lenses* and *Eyeglass Frames* at the same time from the same Spectera Eyecare Networks 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 and contacts.

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

**Necessary Contact Lenses**

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

Contact lenses are necessary if the Insured Person has any of the following:
- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia
- Aniseikonia
- Aniridia
- Post-traumatic disorders

**Low Vision**

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

Benefits include:
- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

**Schedule of Benefits**

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Vision Examination</strong></td>
<td>Once per year.</td>
<td>100% after a Copayment of $20.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td>Once per year.</td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>- Single Vision</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>- Bifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>- Trifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>- Lenticular</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Lens Extras</strong></td>
<td>Once per year.</td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>- Polycarbonate lenses</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>- Standard scratch-resistant coating</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Vision Care Service</td>
<td>Frequency of Service</td>
<td>Network Benefit</td>
<td>Non-Network Benefit</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Each of the following is a separate charge shown under columns Network and Non-Network Benefits:</td>
<td></td>
<td></td>
<td>20% of the billed charge</td>
</tr>
<tr>
<td>- Blended segment lenses,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Intermediate vision lenses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Standard Progressives.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Premium Progressives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Photochromic Glass</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Plastic Photosensitive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Polarized</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hi-Index</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Standard Anti-Reflective Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Premium Anti-Reflective Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ultra Anti-Reflective Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- UV Coating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass Frames</td>
<td>Once per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Eyeglass frames with a retail cost up to $130.</td>
<td>100%</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>- Eyeglass frames with a retail cost of $130 - 160.</td>
<td>100% after a Copayment of $15.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>- Eyeglass frames with a retail cost of $160 - 200.</td>
<td>100% after a Copayment of $30.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>- Eyeglass frames with a retail cost of $200 - 250.</td>
<td>100% after a Copayment of $50.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>- Eyeglass frames with a retail cost greater than $250.</td>
<td>60%</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses Fitting &amp; Evaluation</td>
<td>Once per year.</td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Covered Contact Limited to a 12 month supply.</td>
<td>100% after a</td>
<td>50% of the billed</td>
<td></td>
</tr>
<tr>
<td>Lens Selection</td>
<td>Copayment of $40.</td>
<td>charge.</td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>• Necessary Contact Lenses</td>
<td>Limited to a 12 month supply.</td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Vision Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.</td>
<td>Once every 24 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low vision testing</td>
<td>100% of the billed charge.</td>
<td>75% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>• Low vision therapy</td>
<td>100% of the billed charge.</td>
<td>75% of the billed charge.</td>
<td></td>
</tr>
</tbody>
</table>

**Section 2: Pediatric Vision Exclusions**

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

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

**Section 3: Claims for Pediatric Vision Care Services**

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

**Reimbursement for Vision Care Services**

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

- Insured Person’s itemized receipts.
- Insured Person’s name.
- Insured Person’s identification number 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
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 Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

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

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

**Vision Care Service** - any service or item listed in this section in Section 1: Benefits for Pediatric Vision Care Services.
Schedule of Benefits

University of New Orleans
2017-701-76
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 83.620%

Injury and Sickness Benefits

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

<table>
<thead>
<tr>
<th>Deductible Preferred Provider</th>
<th>$100 (Per Insured Person, Per Policy Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Out-of-Network</td>
<td>$200 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Coinsurance Preferred Provider</td>
<td>80% except as noted below</td>
</tr>
<tr>
<td>Coinsurance Out-of-Network</td>
<td>60% except as noted below</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Provider</td>
<td>$6,850 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Provider</td>
<td>$13,700 (For all Insureds in a Family, Per Policy Year)</td>
</tr>
</tbody>
</table>

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

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. 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.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% when treatment is rendered at the Student Health Center.

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

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Surgery</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon Fees</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>25% of surgery allowance</td>
<td>25% of surgery allowance</td>
</tr>
<tr>
<td>Registered Nurse’s Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician’s Visits</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| Pre-admission Testing  
Payable within 7 working days prior to admission. | Preferred Allowance | Usual and Customary Charges |

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
</table>
| Surgery  
If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. | Preferred Allowance | Usual and Customary Charges |
| Day Surgery Miscellaneous | Preferred Allowance | Usual and Customary Charges |
| Assistant Surgeon Fees | Preferred Allowance | Usual and Customary Charges |
| Anesthetist Services | 25% of surgery allowance | 25% of surgery allowance |
| Physician’s Visits | Preferred Allowance | Usual and Customary Charges |
| Physiotherapy  
All chiropractic care is payable under Physician’s Visits. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. | Preferred Allowance | Usual and Customary Charges |
| Medical Emergency Expenses | Preferred Allowance | Usual and Customary Charges |
| Diagnostic X-ray Services | Preferred Allowance | Usual and Customary Charges |
| Radiation Therapy | Preferred Allowance | Usual and Customary Charges |
| Laboratory Procedures | Preferred Allowance | Usual and Customary Charges |
| Tests & Procedures | Preferred Allowance | Usual and Customary Charges |
| Injections | Preferred Allowance | Usual and Customary Charges |
| Chemotherapy | Preferred Allowance | Usual and Customary Charges |
| Prescription Drugs  
100% of Usual and Customary Charges  
$20 Copay per prescription for generic drugs  
$45 Copay per prescription for brand name up to a 31 day supply per prescription | Preferred Allowance | 100% of Usual and Customary Charges  
$20 Deductible per prescription for generic drugs  
$45 Deductible per prescription for brand name up to a 31 day supply per prescription |

<table>
<thead>
<tr>
<th>Other</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
</tbody>
</table>
| Durable Medical Equipment  
See also Benefits for Prosthetic Devices and Prosthetic Services | Preferred Allowance | 80% of Usual and Customary Charges |
<p>| Consultant Physician Fees | Preferred Allowance | Usual and Customary Charges |
| Dental Treatment and Oral Surgery | Paid as any other Sickness or Injury | Paid as any other Sickness or Injury |
| Mental Illness Treatment | Paid as any other Sickness | Paid as any other Sickness |
| Substance Use Disorder Treatment | Paid as any other Sickness | Paid as any other Sickness |
| Maternity | Paid as any other Sickness | Paid as any other Sickness |
| Complications of Pregnancy | Paid as any other Sickness | Paid as any other Sickness |
| Elective Abortion | No Benefits | No Benefits |</p>
<table>
<thead>
<tr>
<th>Other</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Services</td>
<td>100% of Preferred Allowance</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for a complete list of services provided for specific age and risk groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconstructive Breast Surgery Following Mastectomy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Diabetes Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Outpatient Facility or Clinic</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Approved Clinical Trials</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Pediatric Dental and Vision Services</td>
<td>See Pediatric Dental and Vision Services benefits</td>
<td>See Pediatric Dental and Vision Services benefits</td>
</tr>
<tr>
<td>Cleft Lip and Cleft Palate</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Interpreter Expenses</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Medical Foods</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Benefits are limited to a 31-day supply per purchase.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
</tbody>
</table>
NON-DISCRIMINATION NOTICE

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

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

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

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

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

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

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


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

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

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call 1-866-260-2723.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

請注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請致電 1-866-260-2723.

XIN LUstärke (Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-260-2723.


اتباع: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الواجه الأتدال بـ 1-866-260-2723.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisyè sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-260-2723.

ATTENTION : Si vous parlez français (French), des services d’aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-260-2723.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-260-2723.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-260-2723.

ATTENZIONE: in caso la lingua parlata sia l’italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-260-2723.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-260-2723 an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-260-2723 にお電話ください。

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. 1-866-260-2723
कृपा ध्यान दें: यदि आप हिंदी (Hindi) भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-260-2723

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-260-2723.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jiík'eh, bee ná'ahóóti'. T'áá shoodí kohjjí' 1-866-260-2723 hodîilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-260-2723.