UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

CENTRAL WASHINGTON UNIVERSITY

2023-2024

This Certificate of Coverage is Part of Policy # 2023-686-1

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

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

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

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Introduction

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

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

Nothing contained in the Certificate is designed to restrict the Insured Person in selecting the provider of their choice for care or treatment of a Sickness or Injury.

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

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

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

Women's Right to Direct Access for Women's Health Care Services
Women have direct access to all covered women's health care services. Women's health care services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, within the practitioner's scope of practice. The maternity care, reproductive health, and preventive services include contraceptive services, testing and treatment for sexually transmitted diseases, breast-feeding and complications of pregnancy.

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 undergraduate students taking six (6) or more credit hours, graduate students without an assistantship taking three (3) or more credit hours, post graduate students taking one or more credit hours, pre-doctoral interns, visiting scholars and research scholars are eligible to enroll in this insurance plan. All International students are automatically enrolled in this insurance plan, unless proof of comparable coverage is furnished.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years of age. 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., September 16, 2023. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., September 15, 2024. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. 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.

Special Enrollment Period
Eligible students and their eligible Dependents can also enroll for coverage within 60 days of any of the following qualifying events.

1. Loss of minimum essential coverage under another health plan. This does not include loss of coverage due to an individual's misrepresentation of a material fact affecting coverage, fraud related to the discontinued health coverage, or failure to pay premiums.
2. Loss of eligibility for Medicaid or a public program providing health benefits.
3. Loss of coverage due to dissolution of marriage or termination of a domestic partnership.
4. Loss of coverage due to the death of an employee when covered as a dependent under the employee's health plan.
5. Loss of coverage under another health plan due to termination or reduction of work hours.
6. Permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which the individual was covered does not provide coverage in that person's new service area.
7. Birth, adoption or placement for adoption of a dependent child.
8. A health plan no longer offers any benefits to the class of similarly situated individuals that includes the eligible person.
9. Coverage is discontinued in a qualified health plan by the health benefit exchange and the three month grace period for continuation of coverage has been exhausted.
10. Exhaustion of COBRA coverage due to failure of the employer to remit premium.
11. Loss of COBRA coverage where the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available.
12. Discontinuation of coverage under the Washington State Health Insurance Pool (WSHIP).
13. Loss of coverage as a dependent on a group plan due to age.
14. Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership.

Coverage under the policy will become effective depending on when eligible person's enrollment and the premium are received by the Company.

1. If the individual's enrollment and premium are received between the first and fifteenth day of the month, the coverage will begin on the first day of the following month.
2. If the individual's enrollment and premium are received between the sixteenth day and the last day of the month, the coverage will begin on the first day of the second month.
3. For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption, as applicable, becomes the first effective date of coverage.
4. For special enrollment based on marriage or the beginning of a domestic partnership, and for special enrollment based on loss of minimum essential coverage, coverage becomes effective on the first day of the next month.

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 and Out-of-Network Provider Information

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

The provider network for this plan is Choice.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Right to a Second Opinion

Upon request, the Insured Person has access to a second opinion regarding any medical diagnosis or treatment plan from a Preferred Provider of the Insured's choice. Benefits will be paid the same as for any other Covered Medical Expense in otherwise similar circumstances.

Continuity of Care

In the event a contract or agreement between the Company and a Preferred Provider Physician is terminated by the Company, an Insured under this plan may continue to receive care from that provider at the Preferred Provider level of benefits until the end of sixty (60) days following notice of termination to the Insured Person.

Out-of-Network Preventive Care Services

If the Policy does not have in its PPO network a Preferred Provider who can perform the particular Preventive Care Service, the Policy will cover the item or service when performed by an Out-of-Network Provider and will not impose cost-sharing with respect to the item or service.

Section 6: Medical Expense Benefits

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

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

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

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

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

Inpatient

1. **Room and Board Expense.**
   Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital. Benefits include a private room when the Insured presents to a facility that only has private rooms available for treatment.

2. **Intensive Care.**
   See Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient.

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

4. **Routine Newborn Care.**
   Nursery services and supplies while Hospital Confined and routine nursery care provided immediately after birth for a Newborn Infant including newly adopted children.

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

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

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

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

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

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

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

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

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

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

Outpatient

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

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

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

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

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

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

16. **Physiotherapy.**
    Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    - Physical therapy.
    - Occupational therapy.
    - Cardiac rehabilitation therapy.

- Manipulative treatment.
- Speech therapy.

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

17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
- Facility charge for use of the emergency room and supplies.

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

18. **Diagnostic X-ray Services.**
Means diagnostic imaging (including MRI, CAT Scan, PET Scan, nuclear medicine and diagnostic ultrasound imaging) procedures performed by a Physician on an outpatient basis. 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.**
Means laboratory and pathology procedures performed by a Physician on an outpatient basis. Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures include blood, blood products, blood storage, and services and supplies provided by a blood bank. 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 and procedures will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.
- Outpatient dialysis services.
- Colonoscopies.
- Cardiovascular testing.
- Pulmonary function studies.
- Neurology/neuromuscular procedures.

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, including therapeutic injections and related supplies. 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.

Teaching doses of self-administered injectable medications are limited to three doses per medication per lifetime. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Benefits will also be provided for one early refill of a prescription for topical ophthalmic products without consulting a Physician or obtaining a new prescription if all of the following criteria are met:

- The refill is required by an Insured at or after 70% of the predicted days of use of either the date the original prescription was dispensed or the date the last refill of the prescription was dispensed.
- The prescriber indicates on the original prescription that a specific number of refills will be needed.
- The refill does not exceed the number of refills that the prescriber indicated on the original prescription.

Other

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

26. **Durable Medical Equipment.**
Durable Medical Equipment must be all of the following:

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

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

- Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts.
- Durable medical equipment and mobility enhancing equipment used to serve a medical purpose.
- Cochlear implants.

Benefits include state sales tax for durable medical equipment.

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

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

28. **Dental Injury.**
Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.

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

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

29. **Dental Treatment.**
Dental services or appliances for, or resulting from medical treatment, including oral surgery related to trauma or Injury, if the service is either:

- Emergency in nature.
- Required for extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.

Benefits are also available for Inpatient and outpatient facility and general anesthesia charges when hospitalization is determined to be necessary to safeguard the Insured Person's health while dental services are performed. Benefits do not include charges for the dentist or services received in a dentist's office.

30. **Mental Illness Treatment.**
See Benefits for Mental Disorders and Substance Use Disorders. Benefits for Mental Illness Treatment include coverage for eating disorder treatment when associated with a diagnosis of a DSM categorized mental health condition.

31. **Substance Use Disorder Treatment.**
See Benefits for Mental Disorders and Substance Use Disorders.

32. **Maternity.**
Benefits include all maternity-related services for the following:
- Prenatal and postnatal care and services, including screening.
- Vaginal or cesarean childbirth in a Hospital or birthing center, including the facility fees.
- Coverage of a home birth by a midwife or nurse midwife.
- In-utero treatment for the fetus.
- Prenatal vitamins for a pregnant Insured Person.
- Breast pump for an Insured Person expecting the birth or adoption of a child.
- Medically Necessary screening and diagnostic procedures for prenatal diagnosis of congenital disorders, including all of the following:
  - Hepatitis B surface antigen (HBsAg) screening for the Insured Person during the first trimester of pregnancy and the last trimester of pregnancy if the Insured Person is at high risk for hepatitis B infection.
  - Group B strep screening through prenatal vaginorectal cultures at thirty-five to thirty-seven weeks of gestation. The Insured Person who is currently colonized with Group B strep, or who have unknown Group B strep status, should receive intrapartum treatment in accordance with the current standard of practice in order to reduce risk to the newborn.
  - Maternal serum marker screening for the Insured Person at the beginning of prenatal care if initiated before the twenty-second completed week of gestation.
  - Prenatal ultrasonography during both:
    - The first trimester to establish viability, gestational age, and determine singleton or multiple births.
    - The second trimester for fetal morphology.
  - Additional prenatal ultrasonography at any time during a pregnancy if one or more of the following criteria are met:
    - An Insured Person is undergoing amniocentesis, chorionic villus sampling, or percutaneous umbilical cord blood sampling, or fetal tissue biopsy.
    - The results of a maternal serum marker screening or prenatal cell free DNA test indicates an increased risk to the fetus or pregnancy.
    - There is an increased risk of a congenital abnormality present due to:
      - Environmental exposure.
      - Medical evaluation indicating the possibility of polyhydramnios, oligohydramnios, or poor or accelerated fetal growth.
      - A personal or family history of a congenital abnormality that is potentially detectable by prenatal ultrasound.
  - Amniocentesis after fourteen weeks of gestation.
  - Chorionic villus sampling between ten and fourteen weeks of gestation.
  - Specific fetal diagnostic testing including:
    - Cytogenetic studies on fetal cells including chromosome analysis, targeted cytogenomic microarray analysis (CMA), and fluorescent in-situ hybridization (FISH) for any person undergoing amniocentesis or chorionic villus sampling.
    - DNA testing, biochemical testing, or testing for infectious diseases if medically indicated because of an abnormal ultrasound finding, intrauterine fetal demise, or known family history.
    - Cytogenomic microarray analysis in the case of recurrent intrauterine fetal demise, or known family history.
  - Prenatal cell free DNA testing performed after nine weeks of gestation for the detection of aneuploidy including trisomy 21, 18,13 or the sex chromosomes when specific criteria is met.
  - Carrier screening, limited to once per lifetime, at any time during the pregnancy for recessive or x-linked conditions if indicated by a positive family history and for any of the following conditions irrespective of family history:
    - Alpha-thalassemia (HBA1/HBA2).
    - Beta-thalassemia.
    - Bloom syndrome.
    - Canavan disease.
    - Cystic fibrosis.
    - Familial dysautonomia (IKBKAP).

- Fanconi anemia type C (FANCC).
- Gaucher disease (GBA).
- Mucolipidosis IV (MCOLN1).
- Niemann-Pick disease (SMPD1).
- Sickle cell disease.
- Spinal muscular atrophy (SMN1).
- Tay-Sachs disease (HEXA).
- Fragile-X Syndrome.

- Molecular genetic or cytogenetic testing of parents to allow for definitive fetal testing, or parental testing to better inform results that are suggestive of, but do not identify, a unifying diagnosis and when the results or the parental testing will be used to guide treatment, reproductive decisions, or care planning that would not otherwise be made.
- Percutaneous umbilical cord blood sampling after fifteen weeks of gestation if one or more of the following criteria are met:
  - A medical evaluation indicates rapid or specific submicroscopic chromosomal diagnosis or DNA diagnosis is required to predict prognosis for the fetus.
  - A medical evaluation indicates the possibility of a prenatally diagnosable fetal infection.
  - Fetal blood studies are medical indicated for isoimmunization studies or therapy.
  - Fetal blood is the only means to provide biochemical genetic diagnosis.
  - Prenatal diagnosis of a hematological disorder is medically indicated.
- Prenatal tissue biopsy if the nature of the disorder in question indicated that fetal liver, skin, or other tissue biopsy is the only means to provide biochemical genetic diagnosis to protect the health of the Insured Person or predict the prognosis of the fetus.
- Cytogenomic microarray analysis (CMA) if medical indicated because of an abnormal ultrasound finding or known family history.

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.

Benefits will be provided for abortion of a pregnancy subject to the Policy terms and conditions applicable to Maternity, including applicable Deductibles, Copayments and Coinsurance.

33. **Complications of Pregnancy.**
Benefits include services performed for complications such as, but not limited to, fetal distress, gestational diabetes, and toxemia.

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

Required preventive care services are updated on an ongoing basis as guidelines and recommendations change. The complete and current list of preventive care services covered under the health care reform law can be found at: https://www.healthcare.gov/preventive-care-benefits/.

Preventive care services include screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.

Preventive care services for adults:
- Abdominal aortic aneurysm one-time screening for men age 64 to 75 who have ever smoked.
- Alcohol misuse screening and counseling.

- Anxiety screening for adults.
- Aspirin use to prevent cardiovascular and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.
- Behavioral counseling to promote a healthy diet and physical activity for adults age 18 and older who are at high risk of cardiovascular disease.
- Blood pressure screening.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults 45 and older.
- Depression screening for adults.
- Diabetes (Type 2) and prediabetes screening for adults 35 to 70 years who are overweight or obese.
- Diet/nutrition counseling for adults at higher risk for chronic disease.
- Falls prevention with exercise interventions for adults 65 years and over, living in a community setting.
- Hepatitis B screening for people at high risk, including people from countries with 2 % or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- Hepatitis C screening for adults age 18 to 79.
- HIV screening for everyone ages 15 to 65, and other ages at increased risk.
- Immunization vaccines for adults – doses, recommended ages and recommended populations vary.
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.
- Obesity screening and counseling for all adults, including intensive, multicomponent behavioral weight-loss interventions.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use.
- Preventive care services include screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.
- Screening for unhealthy drug use in adults ages 18 and older. Screening includes asking questions about unhealthy drug use, not testing of biological specimens.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Skin cancer behavioral counseling up to age 24 for adults with fair skin types.
- Statin preventive medication for adults 40 to 75 at high risk.
- Syphilis screening for all adults at higher risk for infection.
- Tobacco use screening and counseling for all adults and cessation interventions, including medications for tobacco use cessation, for tobacco users.
- Tuberculosis screening for certain adults without symptoms at high risk.

Preventive care services for women:

- Anemia screening on a routine basis for pregnant women.
- Anxiety screening for pregnant and postpartum women.
- Behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause.
- Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer.
- Breast cancer mammography screenings every 2 years for women 50 to 74.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies and equipment, for pregnant and nursing women.
- Cervical cancer screening for women age 21 to 65.
- Chlamydia infection screening for all pregnant women, younger women, and other women at higher risk of infection.
- Contraception: Food and Drug Administration-approved contraceptive methods, including insertion or extraction of FDA-approved contraceptive devices, sterilization procedures, including prescription-based sterilization procedures and patient education and counseling, as prescribed by a Physician for women with reproductive capacity (not including abortifacient drugs).
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.

- Gestational diabetes screening for women 24 weeks pregnant or later and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all pregnant women and other women at higher risk of infection.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for everyone ages 15 to 65, and other ages at increased risk.
- Low dose aspirin after 12 weeks gestation for women who are at high risk for preeclampsia.
- Maternal depression screening for mothers at well-baby visits.
- Osteoporosis screening with bone measurement for women age 65 and older.
- Osteoporosis screening with bone measurement in postmenopausal women younger than 65 who are at increased risk of osteoporosis.
- Prenatal and postpartum depression screening.
- Preeclampsia prevention and screening for pregnant women with high blood pressure.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Sexually transmitted infections screening and counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk for infection.
- Tobacco use screening and interventions, including medications for tobacco use cessation, for all women, and expanded intervention and counseling for pregnant tobacco users.
- Urinary incontinence screening.
- Urinary tract or other infection screening for pregnant women.
- Well-woman visits to get recommended services.

Preventive care services for children:

- Alcohol, tobacco and drug use assessments for adolescents.
- Anxiety screenings for children and adolescents ages 8 to 18 years.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Bilirubin concentration screening for newborns.
- Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood screening for newborns.
- Depression screening for adolescents beginning routinely at age 12.
- Developmental screening for children under age 3.
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders.
- Fluoride supplements beginning at age 6 months for children without fluoride in their water source.
- Fluoride varnish for all infants and children as soon as teeth are present.
- Gonorrhea prevention medication for the eyes of all newborns.
- Hearing screening for all newborns and regular screenings for children as recommended by their Physician.
- Height, weight and body mass index (BMI) measurements taken regularly for all children.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for adolescents at higher risk.
- HIV screening for adolescents at higher risk.
- Hypothyroidism screening for newborns.
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary.
- Lead screening for children at risk of exposure.
- Obesity screening for children and adolescents age 6 and older and comprehensive, intensive behavioral interventions to promote improvement in weight status.
- Oral health risk assessment for young children from ages: 6 months to 6 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use.
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- Skin cancer behavioral counseling for ages 6 months to 24 years with fair skin types.
- Syphilis screening for adolescents who are at increased risk for infection.
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children.

- Well-baby and well-child visits.

35. **Reconstructive Breast Surgery Following Mastectomy.**
Reconstructive breast surgery in connection with a covered mastectomy. Benefits include coverage for mastectomy bras and physical complications, such as lymphedemas. See Benefits for Reconstructive Breast Surgery.

36. **Diabetes Services.**
Services received in connection with the treatment of diabetes. See Benefits for Diabetes.

37. **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 will also be paid for home dialysis services.

38. **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.
- Respite care.

39. **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.

40. **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.

Benefits include facility costs, professional and pharmacy services, and prescriptions filled in the Skilled Nursing Facility.

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

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

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

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

43. **Approved Clinical Trials.**
Routine Patient Care Costs incurred while taking part 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 funded by or described in any of the following:

- One of the National Institutes of Health (NIH).
- An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.
- The federal Departments of Veterans Affairs or Defense.
- An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH.
- A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.
- 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.

44. **Transplantation Services.**
Organ or tissue transplants, including artificial organ transplants, when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense. Benefits include transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a Hospital setting or outpatient setting.

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

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

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

45. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits.

46. **Acupuncture Services.**
See Schedule of Benefits. If a visit limit is specified in the Schedule of Benefits, the limit will not be applied to acupuncture services for the treatment of chemical dependency.

47. **Genetic Testing.**
Benefits are limited to genetic testing following genetic counseling when ordered by a Physician and which is determined to be Medically Necessary.

48. **Infertility.**
Benefits are limited to the diagnosis of the underlying causes of infertility.

49. **Medical Foods.**
Medical foods must meet all of the following criteria:
- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of inborn errors of metabolism.

See also Benefits for Phenylketonuria Treatment and Eosinophilic Gastrointestinal Associated Disorder.

50. **Neurodevelopmental Therapy.**
Inpatient and outpatient neurodevelopment services for Insureds with a Neurodevelopmental Delay. For the purpose of this provision, neurodevelopmental delay means a delay in normal development that is not related to any documented Injury or Sickness. Covered services include:
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Maintenance services, if significant deterioration of the Insured's condition would result without the service.

This benefit will not duplicate benefits provided under outpatient Physiotherapy for the same service for the same condition.

51. **Nutritional Counseling.**
Benefits are payable for Medically Necessary nutritional counseling for medical conditions when supported by evidence based medical criteria.

Section 7: Mandated Benefits

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY

Benefits will be provided for reconstructive breast surgery (including prosthesis) resulting from a mastectomy which resulted from disease, illness, or Injury; regardless of when the mastectomy or the condition which made the mastectomy necessary was covered by the Policy.

Benefits will be paid for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. Benefits for reconstructive breast surgery shall be commensurate with the Hospital and surgical benefits otherwise provided by the Policy.
Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations or other provisions of the Policy.

BENEFITS FOR MENTAL DISORDERS AND SUBSTANCE USE DISORDERS

Benefits will be provided for the diagnosis and treatment of Mental Disorders and Substance Use Disorders, including all of the following:

1. Inpatient, residential and outpatient treatment, including partial Hospital programs or inpatient services and home health care services.
2. Chemical dependency detoxification.
3. Behavioral treatment for a *Diagnostic and Statistical Manual of Mental Disorders (DSM)* category diagnosis.
4. Services provided by a licensed behavioral health provider for a covered diagnosis in a Skilled Nursing Facility.
5. Prescription Drugs, including those drugs prescribed during an Inpatient and residential course of treatment.
6. Acupuncture treatment visits without application of any visit limitation requirements, when provided for chemical dependency.
7. Family counseling when the Insured is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for a Mental Disorder.
8. Mental health treatment for diagnostic codes 302 through 302.9 in the DSM, or the "V code" diagnoses for Medically Necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child or children five years of age or younger, and bereavement for children five years of age or younger.
9. Gender dysphoria.
10. Medically Necessary court-ordered Mental Disorder treatment.
11. Treatment and supporting services for Substance Use Disorder, including Withdrawal Management Services or Inpatient or residential Substance Use Disorder treatment services in a licensed or certified behavioral health agency.
12. Services delivered pursuant to involuntary commitment proceedings.

For the purposes of this benefit, “Medical Necessity/Medically Necessary”:

1. With regard to chemical dependency and Substance Use Disorders is defined by the most recent version of The ASAM Criteria, Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions as published by the American Society of Addictive Medicine (ASAM).
2. With regard to Mental Health Services, pharmacy services, and any Substance Use Disorder benefits not governed by ASAM is a Company determination as to whether a health service is a Covered Medical Expense because the service is consistent with generally recognized standards within a relevant health profession.

“Mental health services” means Medically Necessary outpatient and Inpatient services provided to treat Mental Disorders covered by the diagnostic categories listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association consistent with the purposes of chapter 6, Laws of 2005.

“Withdrawal management services” means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

Benefits will be paid as specified in the Policy Schedule of Benefits for Mental Illness Treatment and Substance Use Disorder Treatment and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR DIABETES

Benefits will be provided for the following services and supplies for Insured Persons with diabetes:

1. Medically Necessary equipment and supplies, as prescribed by a Physician, including but not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits.
2. Outpatient self-management training and education, including medical nutrition therapy, as ordered by the Physician. Diabetes outpatient self-management training and education must be provided by providers with expertise in diabetes.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR MAMMOGRAPHY

Benefits will be provided for screening or diagnostic mammography when recommended by a Physician, advanced registered nurse practitioner, or physician assistant.

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 of Benefits.

Mammography not covered by the Preventive Care Services benefit will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be provided for prostate cancer screening when recommended by a Physician.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR PHENYLKETONURIA TREATMENT AND EOSINOPHILIC GASTROINTESTINAL ASSOCIATED DISORDER

Benefits will be provided for the mineral and vitamin-enriched formulas necessary for the treatment of phenylketonuria and use of Medically Necessary elemental formula for eosinophilic gastrointestinal associated disorder.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR SELF-ADMINISTERED ANTICANCER MEDICATIONS

Benefits will be provided for prescribed, self-administered anticancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than for cancer chemotherapy medications that are Covered Medical Expenses under the Policy.

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

BENEFITS FOR ALTERNATIVE CARE FOR HOSPITAL CONFINEMENT

If benefits are provided for Hospital Confinement or institutional expenses, benefits will be provided, at equal or lesser cost, for substitution of home health care, in lieu of Hospital Confinement; furnished by home health, hospice and home care agencies licensed under state statute. These benefits are provided as an alternative to Hospital Confinement and institutional expenses and with the intent to cover placement of an Insured in the most appropriate and cost-effective setting.

Substitution of less expensive or less intensive services shall be made only with the consent of the Insured and receipt of a written treatment plan approved by the Insured's treating Physician recommending such care.
Benefits will be limited to the maximum benefits which would be payable for Hospital Confinement.

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

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER

Benefits will be provided for the treatment of temporomandibular joint disorders.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR OFF-LABEL PRESCRIPTION DRUGS

Benefits will be paid the same as any other Prescription Drug prescribed to treat an Insured resident in the state of Washington when that drug has not been approved by the Federal Food and Drug Administration for that indication, if such drug is recognized as effective for treatment:

1. In one of the Standard Reference Compendia.
2. In the majority of relevant Peer-Reviewed Medical Literature if not recognized in one of the Standard Reference Compendia.
3. By the Federal Secretary of Health and Human Services

Benefits will include Medically Necessary services associated with the administration of the Prescription Drug.
Benefits will not be paid for:

1. The use of any Drug when the FDA has determined that use to be contraindicated
2. Any experimental Drug not otherwise approved for any indication by the FDA.

"Off-label" means the prescribed use of a drug which is other than that stated in its FDA approved labeling.

"Peer-Reviewed Medical Literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

"Standard Reference Compendia" means:

1. The American Hospital Formulary Service-Drug Information;
2. The American Medical Association Drug Evaluation;
3. The United States Pharmacopoeia-Drug Information; or
4. Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the insurance commissioner.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be provided for colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States Preventive Services Task Force or the federal centers for disease control and prevention.

Benefits will be provided for any colorectal screening examination and test in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the Insured Person's Physician after for an Insured who is either:

1. At least fifty (50) years of age.
2. Less than fifty (50) years of age and at high risk for colorectal cancer according to such guidelines and recommendations.

If a Preferred Provider is not available to administer colorectal cancer screening services, benefits will be paid at the level of benefits shown as Preferred Provider benefits listed in the Schedule of Benefits.

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 of Benefits.

Colorectal cancer screening not covered by the Preventive Care Services benefit will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CONTRACEPTIVES

Benefits will be provided for prescription contraceptives approved by the United States Food and Drug Administration (FDA) on a basis no less favorable than for other covered Prescription Drugs and devices. Benefits will be provided for the medical services associated with prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.

Prescription contraceptives include FDA approved Contraceptive Drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.

Benefits will be provided for up to a 12-month refill supply of prescription Contraceptive Drugs when prescribed to be dispensed at one time, unless the Insured requests a smaller supply or the prescribing Physician instructs that the Insured must receive a smaller supply. If a 12-month refill extends beyond the Policy termination date, benefits will be provided for the number of months up to the Policy termination date.

The Insured Person may receive the Contraceptive Drug on-site at the Physician's office, if available.

"Contraceptive Drugs" means all drugs approved by the FDA that are used to prevent pregnancy, including but not limited to, hormonal drugs administered orally, transdermally, and intravaginally.

Benefit will also be provided for the following contraceptive methods:

1. All over-the-counter contraceptive drugs, devices, and other products approved by the FDA. This includes condoms, regardless of the gender or sexual orientation of the Insured Person, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections. To request reimbursement for over-the-counter contraceptive drugs, devices, and other products, an Insured should submit a claim as described in the "How to File a Claim for Injury and Sickness Benefits" in this Certificate.
2. Voluntary sterilization procedures.
3. The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices and other products or services specified in 1 and 2 above.

No prescription is required for over-the-counter contraceptive drugs, devices, and products approved by the FDA.

Benefits will not be denied because an Insured changed his or her contraceptive method within a twelve-month period.

Benefits apply to all Insured Person's and will not be denied on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability.

Prescription contraceptives covered by the Preventive Care Services Benefit shall be paid as specified in the Preventive Care Services Benefit listed in the Schedule of Benefits. Contraceptive methods received from a Preferred Provider shall not be subject to a Deductible, Copayment or Coinsurance. When received from an Out-of-Network Provider, contraceptive benefits shall be subject to all Deductible, Copayment, Coinsurance limitations or any other provisions of the Policy.

BENEFITS FOR HEALTH CARE NEEDS FROM A SEXUAL ASSAULT

Benefits will be paid the same as any other Sickness for the Medically Necessary services and Prescription Drugs for the treatment of physical, mental, sexual and reproductive health care needs that arise from a sexual assault of an Insured Person.

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

BENEFITS FOR GENDER AFFIRMING TREATMENT

Benefits will be paid the same as any other Sickness for Medically Necessary Gender Affirming Treatment when prescribed to an Insured because of, related to, or consistent with the Insured Person's gender expression or identity and in accordance with accepted standards of care.

Benefits will include Medically Necessary cosmetic procedures and services in relation to Gender Affirming Treatment.

"Gender affirming treatment" means a service or product that a health care provider, as defined in RCW 70.02.010, prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Gender affirming treatment must be covered in a manner compliant with the federal mental health parity and addiction equity act of 2008 and the federal affordable care act. Gender affirming treatment can be prescribed to two spirit, transgender, nonbinary, intersex, and other gender diverse individuals.

For further information regarding Gender Affirming Treatment, such as descriptions of clinically appropriate and accepted standards of care, including applicable limitations, please refer to the reference document which can be found here:

www.uhcprovider.com/content/dam/provider/docs/public/policies/signaturevalue-bip/gender-dysphoria-gender-identity-disorder-treatment-wa.pdf

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

BENEFITS FOR DONOR HUMAN MILK

Benefits will be paid the same as any other Sickness for Medically Necessary Donor Human Milk for Inpatient use when ordered by a licensed health care provider or international board certified lactation consultant for an infant who is medically or physically unable to receive human milk or participate in chest feeding, or whose parent is medically or physically unable to produce milk in sufficient quantities or calories density or participate in chest feeding, if the infant meets at least one of the following:

1. An infant birth weight of below 2,500 grams.
2. An infant gestational age equal to or less than 34 weeks.
3. Infant hypoglycemia.
4. A high risk for development of necrotizing enterocolitis, bronchopulmonary dysplasia, or retinopathy of prematurity.
5. A congenital or acquired gastrointestinal condition with long-term feeding or malabsorption complications.
6. Congenital heart disease requiring surgery in the first year of life.
7. An organ or bone marrow transplant.
8. Sepsis.
9. Congenital hypotonias associated with feeding difficulty or malabsorption.
10. Renal disease requiring dialysis in the first year of life.
11. Craniofacial anomalies.
12. An immunologic deficiency.
13. Neonatal abstinence syndrome.
14. Any other serious congenital or acquired condition for which the use of pasteurized donor human milk and donor human milk derived products is medically necessary and supports the treatment and recovery of the child.
15. Any baby still inpatient within 72 hours of birth without sufficient human milk available.

"Donor human milk" means human milk that has been contributed to a Milk Bank by one or more donors.

"Milk bank" means an organization that engages in the procurement, processing, storage, distribution, or use of human milk contributed by donors

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

Section 8: Coordination of Benefits Provision

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

Notice to Insured Persons: If you are covered by more than one health benefit plan, and you do not know which is your Primary Plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

Definitions

1. **Allowable Expenses:** Any health care service or expense, including Coinsurance, or Copays and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. When coordination benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, totals the same allowable expense as the secondary plan would have paid if it was the primary plan. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health Plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health Plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.
   - The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
   - For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
   - For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.

2. **Closed Panel Plan:** A plan that provides health benefits to covered persons in the form of services primarily through a panel of providers that are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

   Plan includes all of the following:
   - Group, individual or blanket insurance contracts and subscriber contracts.
   - Group or individual coverage through closed panel Plans.
   - The medical care components of long-term care contracts, such as skilled nursing care.
   - Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of Plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

   Plan does not include any of the following:
   - Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage.
   - Accident only coverage.

- Limited benefit health coverage as defined by state law.
- Specified disease or specified accident coverage.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
- Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
- Medicare supplement policies.
- State Plans under Medicaid.
- A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.
- Automobile insurance policies required by statute to provide medical benefits.
- Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by state law (section 3, chapter 267, Laws of 2007).

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

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

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

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

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

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan. The Secondary Plan determines its benefits after those of another Plan and must make payment in an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all plans for the claim equal 100% of the Total Allowable Expense for that claim. The Secondary Plan must pay the amount which, when combined with what the Primary Plan paid, totals 100% of the highest Allowable Expense. In addition, the Secondary Plan must calculate its savings (the amount paid by the Secondary Plan subtracted from the amount it would have paid had it been the Primary Plan) and record these savings as a benefit reserve for the Insured Person. This reserve must be used to pay any expenses during that Policy Year, whether or not they are an Allowable Expense under the Policy. The Company is not required to pay an amount in excess of its maximum benefit plus any accrued savings if this Policy is the Secondary Plan.

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

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

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

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

1. **Non-Dependent/Dependent.** The benefits of the Plan which covers the person other than as a Dependent, for example as an employee, member or subscriber, Policyholder or retiree, are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the Plan covering the person as a dependent; and (ii) primary to the Plan covering the person as other than a dependent, then the order of benefit is reversed. The Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
   - The benefits of the Plan of the parent whose birthday falls earlier in a calendar year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
   - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

3. **Dependent Child/Parents Divorced, Separated or Not Living Together.** If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

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

   If a court decree states one parent is to assume primary financial responsibility for the child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary.

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

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

   If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:
   - First, the Plan of the parent with custody of the child.
   - Then the Plan of the spouse of the parent with the custody of the child.
   - The Plan of the parent not having custody of the child.
   - Finally, the Plan of the spouse of the parent not having custody of the child.

4. **Dependent Child/Non-Parental Coverage.** If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.

5. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   - First, the benefits of a Plan covering the person as an employee, member, subscriber, retiree, or as that person's Dependent.
   - Second, the benefits under the COBRA or continuation coverage.
   - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered the Insured Person longer are determined before those of the Plan which covered that person for the shorter time.

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

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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

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

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

Section 9: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight
If such Injury shall independently of all other causes and within 12 months from the date of Injury solely result in any one of the following specific losses, the Company will pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of	
Life	$25,000.00
Two or More Members	$25,000.00
One Member	$12,500.00
Thumb or Index Finger	$ 6,250.00

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

Section 10: Continuation Privilege

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

Application must be made and premium must be paid directly to UnitedHealthcare Student Resources and be received within 31 days after the expiration date of the Insured’s coverage. For further information on the Continuation Privilege, please contact UnitedHealthcare Student Resources.

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 60 days.

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. Coverage for a newborn adopted 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 60 days. If additional premium is required to continue the coverage, the Insured must, within the 60 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 60 days after the child's date of placement. The time limit on notifying the Company does not apply when additional premium is not required.

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

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

Allowed amounts are based on the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

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

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.

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

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

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

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 developmentally or physically disabled as defined by subsections (1) and (2).

DOMESTIC PARTNER means two persons who meet all of the following requirements:

1. Both persons share a common residence.
2. Both persons are at least eighteen years of age and at least one of the persons is sixty-two years of age or older.
3. Neither person is married to someone other than the party to the domestic partnership and neither person is in a state registered domestic partnership with another person.
4. Both persons are capable of consenting to the domestic partnership.
5. Both of the following are true:
   a. The persons are not nearer of kin to each other than second cousins, whether of the whole or half-blood computing by the rules of the civil law.
   b. Neither person is a sibling, child, grandchild, aunt, uncle, niece, or nephew to the other person.

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 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, all of the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.
2. Emergency room and department-based services, supplies, and treatment, including professional charges, facility costs, and outpatient charges for patient observation.
3. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)*).
4. Prescription Drugs associated with a Medical Emergency, including those purchased in a foreign country.

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

1. The attending Physician or treating provider for the Medical Emergency determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Preferred Provider or

Preferred Provider facility located within a reasonable distance taking into consideration the patient's medical condition.
2. The provider furnishing the additional items and services satisfied the notice and consent criteria in accordance with applicable law.
3. The patient is in such a condition to receive information as stated in 2 above and to provide informed consent in accordance with applicable law.
4. The provider or facility satisfied any additional requirements or prohibitions as may be imposed by state law.

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

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

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

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

1. Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
4. In determining whether services are experimental or investigational, the Company will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.
5. In determining whether services are experimental or investigational, the Company will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient.

Exceptions:

1. Clinical trials for which Benefits are available as described under Approved Clinical Trials in *Section 5: Medical Expense Benefits.*
2. If the Insured Person is not a participant in a qualifying clinical trial, as described under Approved Clinical Trials in Section 5: Medical Expense Benefits, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment, the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first be established if there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

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

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

INJURY means bodily injury which is all of the following:

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

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

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

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

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

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

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

MEDICAL NECESSITY/MEDICALLY NECESSARY means 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.

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

MENTAL DISORDER means a Sickness covered by the diagnostic categories listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association. Mental disorders must be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the most current version of the *International Classification of Diseases (ICD)*, or state guidelines).

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 60 days after birth. 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 60 days. If additional premium is required to continue the coverage, the Insured must, within the 60 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 60 days after the child's birth. The time limit on notifying the Company does not apply when additional premium is not required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBSTANCE USE DISORDER means a substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

TELEHEALTH/TELEMEDICINE means the delivery of health care services through the use of interactive audio and video technology, or audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include, facsimile, email or text messaging, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work.

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

Section 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. Biofeedback.
3. Cosmetic procedures intended to alter or reshape normal structures of the body in order to change or improve appearance or alter or reshape normal structures of the body without significantly improving physiological function.
   - Cosmetic procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy will be paid the same as any other Sickness or Injury.
   - Cosmetic procedures to treat or correct a congenital anomaly will be paid the same as any other Sickness.

   This exclusion does not apply to benefits specifically provided in Benefits for Gender Affirming Treatment.
4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
5. Dental treatment.
   - Benefits will be provided for accidental Injury to Sound, Natural Teeth as described under Dental Injury in Section 6: Medical Expense Benefits.
   - Benefits will be provided for additional covered Dental Treatment as described under Dental Treatment in Section 6: Medical Expense Benefits

   Benefits will be provided for Pediatric Dental Services as described in Section 21: Pediatric Dental Services Benefits.
6. Elective Surgery or Elective Treatment.
7. Flight in any kind of aircraft. Injuries sustained while riding as a passenger on a regularly scheduled flight of a commercial airline, or a chartered aircraft only while participating in a school sponsored intercollegiate sport activity, will be covered the same as any other Injury.
8. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   Benefits will be provided for preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease as described under Diabetes Services in Section 6: Medical Expense Benefits and as described under Benefits for Diabetes in Section 7: Mandated Benefits.
9. Genetic testing.
   Benefits will be provided for Medically Necessary genetic testing and maternity related genetic testing as described under Maternity and Genetic Testing in Section 6: Medical Expense Benefits.
10. Health spa or similar facilities. Strengthening programs.
11. 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.
    - Benefits will be provided for Medically Necessary treatment of hearing defects or hearing loss as a result of an infection or Injury.
    - Benefits will be provided for cochlear implants as described under Durable Medical Equipment in Section 6: Medical Expense Benefits.
12. Hirsutism. Alopecia.

13. Hypnosis.
14. Immunizations. Preventive medicines or vaccines..
    Benefits will be provided for immunizations or preventive medicines or vaccines provided under the *United States Preventive Task Force* requirements or the *Health Resources and Services Administration (HRSA)* requirements as described under Preventive Care Services in Section 6: Medical Expense Benefits.
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 or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency or when traveling for academic study abroad programs, business or pleasure.
17. Investigational services.
18. Lipectomy.
19. Marital counseling, except family counseling as specifically provided in Benefits for Mental Disorders and Substance Use Disorders.
20. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
21. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use.
      Benefits will be provided for durable medical equipment as described under Durable Medical Equipment in Section 6: Medical Expense Benefits.
    - Immunization agents.
      Benefits will be provided for immunization agents provided under the *United States Preventive Task Force* requirements or the *Health Resources and Services Administration (HRSA)* requirements as described under Preventive Care Services in Section 6: Medical Expense Benefits
    - 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.
    - Growth hormones.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
22. Reproductive services for the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
      Benefits will be provided for Medically Necessary genetic testing and maternity related genetic testing as described under Maternity and Genetic Testing in Section 6: Medical Expense Benefits.
    - 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.
      Benefits will be provided for the diagnosis of the underlying cause of the infertility as described under Infertility in Section 6: Medical Expense Benefits.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Reversal of sterilization procedures.
23. 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.
    Benefits will be provided for treatment of approved clinical trials as described under Approved Clinical Trials in Section 6: Medical Expense Benefits.
24. 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.
    - Benefits will be provided for Medically Necessary eye examination services, vision correction surgery, or treatment for visual defects or problems when due to a covered Injury or disease process.
    - Benefits will be provided for Pediatric Vision Care Services as described in Section 22: Pediatric Vision Services Benefits.
    - Benefits will be provided for limited vision care supplies listed in the Schedule of Benefits.
25. Routine Newborn Infant Care and well-baby nursery and related Physician charge.
    Benefits will be provided for newborn care provided immediately after birth as described under Routine Newborn Care in Section 6: Medical Expense Benefits.
26. 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.

27. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
28. Bungee jumping.
29. Sleep disorders.
    Benefits will be provided the same as any other Sickness for orthognathic surgery due to sleep apnea.
30. Supplies not mentioned in Section 6: Medical Expense Benefits or in Section 7: Mandated Benefits.
31. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia. This exclusion does not apply to benefits specifically provided in Benefits for Gender Affirming Treatment.
    Benefits will be provided for breast surgery as described under Reconstructive Breast Surgery Following Mastectomy in Section 6: Medical Expense Benefits and as described under Benefits for Reconstructive Breast Surgery in Section 7: Mandated Benefits.
32. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
33. 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).
34. Weight management. Weight reduction. Nutrition programs. Non-surgical treatment for obesity. Surgery for removal of excess skin or fat.
    Benefits will be provided for surgery related to morbid obesity.
    Benefits will be provided for obesity services as shown on the A & B list of preventive services as recommended by the *United States Preventive Task Force* as described under Preventive Care Services in Section 6: Medical Expense Benefits.

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

In the event of Injury or Sickness, students should:

1. Report to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/MyAccount or submit claims by mail. If submitting by mail, send to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated. If you are covered by more than one health benefit plan, and you do not know which one is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

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

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

Section 14: General Provisions

GRACE PERIOD: A grace period of 10 days for monthly premium policies and 31 days for all other policies will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

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, be paid directly to the Hospital or person rendering such service, unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss.

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

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

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization.

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

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 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 shall recover only that portion paid by the Company which is in excess of the amount necessary to fully compensate the Insured for all expenses incurred as a result of his loss. The Insured shall be permitted to recoup his general damages, which is not limited to medical expenses, from the tort-feasor before subrogation provided that in so doing, the Insured does not prejudice the rights of the Company.

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

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

Section 15: Complaint Resolution

Insured Persons and Providers or their representatives may call the Customer Service Department at 800-767-0700 with questions or a Grievance. If the question or Grievance is not resolved to the satisfaction of the complainant, the complainant must submit, to the Company, a written request for resolution to the Grievance. A thorough investigation will be made and the Company will respond with a resolution within 45 business days. The Company will not retaliate against the complainant because of the Grievance.

“Grievance” means a complaint submitted by or on behalf of an Insured Person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the Company.

The resolution to the Grievance is not considered an Adverse Determination. If the complaint is the result of an adverse benefit determination, the Insured Person has the right to request a separate internal review of the Adverse Determination.

Section 16: 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 an oral or written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination. The Company will acknowledge receipt of the request for an Internal Appeal. An oral request shall be reduced to writing by the Company and a copy will be forwarded to the Insured Person, or the Insured Person's Authorized Representative.

If submitting a written request for an Internal Appeal, the 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.

The right to request an Internal Appeal is accessible to an Insured Person who has a physical or mental disability, literacy issues or is a limited-English speaker. Please contact the Customer Service Department at 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare Student Resources, PO Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process
Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination. If the request for review is related to services the Insured Person is currently receiving, a course of treatment which is Medically Necessary, or receiving as an Inpatient, those services will continue until the Insured Person has been notified of the final determination. If the Company upholds the Adverse Benefit Determination, the Insured Person may be responsible for the cost of these continued services.

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 72 hours after receipt of the review request, 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 review request; 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 within 14 days of receipt of the request for review, unless the Adverse Benefit Determination involves an experimental or investigational treatment. In the case of an Adverse Benefit Determination involving an experimental or investigational treatment, the Company will issue Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative within 20 days of receipt of the request for review.

The Company may extend the time it takes to issue a Final Adverse Decision, with good cause, by up to 16 additional days without the Insured's written consent and will notify the Insured Person or the Authorized Representative if the extension and reason for the extension. If further time is necessary for the Company to issue a Final Adverse Decision after the first extension, the Company must request the Insured Person's consent. The further extension request will be reduced to writing and will include a specific agreed upon date for determination.

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 review request, 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 or ombudsman's office for assistance with respect to any claim, review request or appeal at any time.

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

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

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

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

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

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

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

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

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

The notice of Final Adverse Determination shall be provided orally, followed by a notice provided either in writing, or electronically.

RIGHT TO EXTERNAL INDEPENDENT REVIEW

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

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 180 days 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 provide the Insured Person or the Authorized Representative with the appropriate forms to request the review. If the request for review is related to a services the Insured Person is currently receiving a course of treatment which is Medically Necessary or is receiving as an Inpatient, those services will continue until the Insured Person has been notified of the final determination.

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 Student Resources
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 180 days of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

1. After receiving a request for External Review, the Company shall, within one business day:
   a. Refer the case to an Independent Review Organization (IRO) using the rotational registry system of certified IRO's established by the Commissioner;
   b. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within five business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

2. a. The Company shall, within three business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within one business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
3. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
4. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
   b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
   c. If the Company reverses it decision, the Company shall provide written notification within one business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
5. Within 15 days after receiving necessary information or within 20 days after receipt of the SER request, whichever is earlier, 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 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. After receiving a request for an EER, the Company shall immediately refer the case to an Independent Review Organization (IRO) using the rotational registry system of certified IRO's established by the Commissioner.
   a. The Company shall immediately 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.
3. 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 review request remains unresolved at the end of the EIR process.
4. 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 Company, the Insured Person, and, if applicable, the Authorized Representative.
5. 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.

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. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

Office of the Washington State Insurance Commissioner
Consumer Protection Division
PO BOX 40256
Olympia, WA 98504-0256
(800) 562-6900
https://www.insurance.wa.gov/your-insurance/health-insurance/appeal/

Section 17: Online Access to Account Information

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

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

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

Section 18: 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 19: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. 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 20: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

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

Sales/Marketing Services:
UnitedHealthcare Student Resources
11399 16th Court North, Suite 110
St. Petersburg, FL 33716
Email: info@uhcsr.com

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

A list of health care benefit managers utilized by UnitedHealthcare Insurance Company can be accessed at https://www.uhcsr.com/regulatory-state.

Section 21: 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.

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

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

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

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

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

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

What Are Covered Dental Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are provided. 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.

Network Benefits:

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

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

Out-of-Network Benefits:

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

Benefits

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

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

Benefit Description

Diagnostic Services (Preventive and Diagnostic)

- Clinical oral evaluations:
  - Comprehensive oral evaluation including:
    - Complete dental/medical history and general health assessment;
    - Complete thorough evaluation of extra-oral and intra-oral hard and soft tissue;
    - The evaluation and recording of dental caries, missing or unerupted teeth restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies and oral cancer screening;
  - Periodic oral evaluation – subsequent thorough evaluation of an established patient to determine the need for sealants, fluoride and/or treatment setting;
  - Oral evaluation for patient under the age of 3 and counseling with primary caregiver;
  - Limited oral evaluations that are problem focused; and

- Detailed oral evaluations that are problem focused.
- Diagnostic Imaging with interpretation:
  - A full mouth series;
  - An extraoral panoramic film;
  - Bitewings, periapicals, panoramic and cephlometric radiographic images;
  - Intraoral and extraoral radiographic images;
  - Oral/facial photographic images;
  - Maxillofacial MRI, ultrasound; and
  - X-rays not listed above, on a case-by-case basis, when Medically Necessary.
- Tests and Examinations, including one pulp vitality test per visit.
- Viral culture.
- Collection and preparation of saliva sample for laboratory diagnostic testing.
- Diagnostic casts – for diagnostic purposes only and not in conjunction with other services.
- Oral pathology laboratory:
  - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report;
  - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report;
  - Other oral pathology procedures, by report.

Preventive Services (Preventive and Diagnostic)

- Dental prophylaxis.
- Topical fluoride treatment, including fluoride rinse, foam or gel, including disposable trays for the treatment.
- Fluoride varnish.
- Sealants.
- Oral hygiene instruction, including individualized oral hygiene instructions, tooth brushing techniques, flossing and use of oral hygiene aids, every 12 months for ages 8 and under, only if not billed on the same day with dental prophylaxis.
- Space maintainers - to maintain space for eruption of permanent tooth/teeth, includes placement and removal:
  - Fixed - unilateral and bilateral;
  - Removable - bilateral only;
  - Recementation of fixed space maintainer;
  - Removal of fixed space maintainer - considered for provider that did not place appliance.

Restorative Services (Basic)

- Restorations (fillings) - amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
- Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion.

Adjunctive General Services (Basic)

- Palliative treatment for emergency treatment – per visit.
- Anesthesia:
  - Local anesthesia NOT in conjunction with operative or surgical procedures;
  - Regional block;
  - Trigeminal division block;
  - Deep sedation/general anesthesia;
  - Intravenous conscious sedation/analgesia;
  - Nitrous oxide/analgesia;
  - Non-intravenous conscious sedation; and
  - Office visit for observation – (during regular hours) no other service performed.
- Drugs:
  - Therapeutic parenteral drug;
    - Single administration; and
    - Two or more administrations - not to be combined with single administration.
  - Other drugs and/or medicaments – by report.
- Application of desensitizing medicament – per visit.
- Occlusal guard – for treatment of bruxism, clenching or grinding.
- Athletic mouthguard covered once per year.
- Occlusal adjustment.
- Odontoplasty.

- General Services (including Emergency Treatment, behavior management, 2 house/extended care facility calls, 1 hospital call, and treatment of post-surgical complications as described in Section 1: Covered Health Services under Physician's Office Services - Sickness and Injury.

Endodontic Services (Basic)

- Therapeutic pulpotomy for primary and permanent teeth.
- Pulpal debridement for primary and permanent teeth.
- Partial pulpotomy for apexogensis.
- Pulpal therapy for anterior and posterior primary teeth.
- Endodontic therapy and retreatment.
- Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation.
- Apexification: initial, interim and final visits.
- Pulpal regeneration.
- Apicoectomy/Periradicular Surgery.
- Retrograde filling.
- Root amputation.
- Surgical procedure for isolation of tooth with rubber dam.
- Hemisection.
- Canal preparation and fitting of preformed dowel or post.
- Post removal.

Oral Surgery and Maxillofacial Surgical Services (Basic)

- Extraction of teeth:
  - Extraction of coronal remnants - deciduous tooth;
  - Extraction, erupted tooth or exposed root;
  - Surgical removal of erupted tooth or residual root;
  - Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications.
- Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
- Other surgical Procedures:
  - Oroantral fistula;
  - Primary closure of sinus perforation and sinus repairs;
  - Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident;
  - Surgical access of an unerupted tooth;
  - Mobilization of erupted or malpositioned tooth to aid eruption;
  - Placement of device to aid eruption;
  - Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy;
  - Surgical repositioning of tooth/teeth;
  - Transseptal fiberotomy/supra crestal fiberotomy;
  - Surgical placement of anchorage device with or without flap; and
  - Harvesting bone for use in graft(s).
- Alveoloplasty in conjunction or not in conjunction with extractions.
- Vestibuloplasty.
- Excision of benign and malignant tumors/lesions.
- Removal of cysts (odontogenic and nonodontogenic) and foreign bodies.
- Destruction of lesions by electrosurgery.
- Removal of lateral exostosis, torus palatinus or torus madibularis.
- Surgical reduction of osseous tuberosity.
- Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
- Surgical Incision:
  - Incision and drainage of abcess - intraoral and extraoral;
  - Removal of foreign body;
  - Partial ostectomy/sequestrectomy; and
  - Maxillary sinusotomy.
- Fracture repairs of maxilla, mandible and facial bones - simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
- Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage.
- Arthroscopy.
- Occlusal orthotic device - includes placement and removal to same provider.

- Surgical and other repairs:
  - Skin and bone graft and synthetic graft;
  - Collection and application of autologous blood concentrate;
  - Osteoplasty and osteotomy;
  - LeFort I, II, III with or without bone graft;
  - Graft of the mandible or maxilla - autogenous or nonautogenous;
  - Frenectomy and frenoplasty;
  - Excision of hyperplastic tissue and pericoronal gingiva;
  - Appliance removal - "by report" for provider that did not place appliance, splint or hardware.

Periodontal Services (Basic)

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

Crowns - (Major)

- Inlay/onlay restorations - metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program.
- Porcelain fused to metal, cast and ceramic crowns (single restoration) - to restore form and function.
- Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown.
- Prefabricated stainless steel, stainless steel crown with resin window and resin crowns.
- Retreatment for the removal of post, pin, or old root canal filling material.
- Core buildup, including pins.
- Pin retention.
- Indirectly fabricated (custom fabricated/cast) and prefabricated post and core.
- Additional fabricated (custom fabricated/cast) and prefabricated post.
- Post removal.
- Temporary crown (fractured tooth).
- Additional procedures to construct new crown under existing partial denture.
- Coping.
- Crown repair.
- Protective restoration/sedative filling.

Prosthodontic Services (Major)

- Complete dentures and immediate complete dentures - maxillary and mandibular to address masticatory deficiencies.
- Partial denture - maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic):
  - Resin base and cast frame dentures including any conventional clasps, rests and teeth;
  - Flexible base denture including any clasps, rests and teeth; and
  - Removable unilateral partial dentures or dentures without clasps are not considered.
- Overdenture - complete and partial.

- Denture adjustments - 6 months after insertion or repair.
- Denture repairs - includes adjustments for first 6 months following service.
- Denture rebase denture rebase is covered and includes adjustments for first 6 months following service.
- Denture relines - includes adjustments for first 6 months following service.
- Precision attachment, by report.
- Fixed and Partial Dentures.
- Maxillofacial prosthetics - includes adjustments for first 6 months following service:
  - Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis - initial, interim and replacement;
  - Obturator prosthesis: surgical, definitive and modifications;
  - Mandibular resection prosthesis with and without guide flange;
  - Surgical stents;
  - Radiation carrier;
  - Topical medicament carrier;
  - Adjustments, modification and repair to a maxillofacial prosthesis;
  - Maintenance and cleaning of maxillofacial prosthesis.

Implant Services (Major)

- Covered services include: implant body, abutment and crown.
- Implant - mandibular augmentation purposes.

Medically Necessary Orthodontic Services (Major)

Orthodontic Treatment requires prior authorization and is not considered for cosmetic purposes. Treatment must meet all criteria of Medical Necessity. Coverage includes:

- Limited treatment for the primary, transitional.
- Interceptive treatment for the primary and transitional dentition.
- Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate Medical Necessity.
- Orthognathic Surgical Cases with comprehensive orthodontic treatment.
- Repairs to orthodontic appliances.
- Replacement of lost or broken retainer.
- Rebonding or recementing of brackets and/or bands.

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Diagnostic Services		
Evaluations (Checkup Exams) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following service is not subject to a frequency limit. D0160 - Detailed and extensive oral evaluation - problem focused, by report		
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Intraoral complete series of radiographic images D0709 - Intraoral - complete series of radiographic images - image capture only	50%	50%
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only	50%	50%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0708 - Intraoral - bitewing radiographic image - image capture only	50%	50%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only D0704 - 3-D Photographic image - image capture only	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following service is limited to 2 images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%	50%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	50%	50%
Preventive Services		
Dental Prophylaxis (Cleanings) The following services are limited to 2 times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%	50%
Fluoride Treatments The following services are limited to 3 times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish	50%	50%
Sealants (Protective Coating) The following services are limited to once per bicuspid and first or second permanent molar every 24 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%	50%
Space Maintainers (Spacers) The following services are not subject to a frequency limit and includes replacement of space maintainers when Necessary. D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed - bilateral maxillary	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant		
Minor Restorative Services		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)	50%	50%
Crowns/Inlays/Onlays		
The following services are subject to a limit of 1 time every 60 months. D2542 - Onlay - metallic - two surfaces	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2740 - Crown - porcelain/ceramic D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following services are limited to 1 time per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth D2950 - Core buildup, including any pins when required	50%	50%
The following service is limited to 1 time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to restoration	50%	50%
The following service is not subject to a frequency limit.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2954 - Prefabricated post and core in addition to crown		
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	50%	50%
Endodontics		
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration)	50%	50%
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%	50%
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3310 - Endodontic therapy anterior tooth (excluding final restoration) D3320 - Endodontic therapy premolar tooth (excluding final restoration) D3330 - Endodontic therapy molar tooth (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit		
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - bicuspid premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy - (each additional root) D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	50%	50%
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics		
The following services are limited to a frequency of 1 every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following services are limited to 1 every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard tissue		
The following services are limited to 1 every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft - retained natural tooth - first site in quadrant	50%	50%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure	50%	50%
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth positions in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure - each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns	50%	50%
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following service is limited to a frequency to 1 per every 3 years. D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit	50%	50%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures		
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 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture (each tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture	50%	50%
The following services are limited to rebasing performed more than 6 months after the initial insertion with a	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)		
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%	50%
Bridges (Fixed partial dentures)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are limited to 1 time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal	50%	50%
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond FPD	50%	50%
The following service is not subject to a frequency limit. D6980 - FPD repair necessitated by restorative material failure	50%	50%
Oral Surgery		
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root	50%	50%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
elevation of mucoperiosteal flap, if indicated D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal		
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%	50%
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess, intraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D7960 - Frenulectomy - also known as Frenectomy or Frenotomy - separate procedure not incidental to another procedure D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7963 – Frenuloplasty D7971 - Excision of pericoronal gingiva		
Adjunctive Services		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure	50%	50%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration	50%	50%
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
The following is limited to 1 guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch	50%	50%
Implant Procedures		
The following services are limited to 1 time every 60 months. D6010 - Surgical placement of implant body: endosteal implant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment D6095 - Repair implant abutment D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant replacement D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 - Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		
Medically Necessary Orthodontics		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy, medical conditions as indicated on the Washington Modified Handicapping Labiolingual Deviation (HDL) Index Score that result in a score of 25 or higher, or other severe craniofacial deformities, including but not limited to, hemifacial macrosomia, craniosynostosis syndromes, Arthrogryposis, and Marfan syndrome, which result in a physically handicapping malocclusion as determined by the Company's dental consultants. The Company reviews all requests for treatment for conditions that result in a score of less than 25 on a case-by-case basis, with consideration of Medical Necessity. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular		

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through the Policy.

16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 22: Pediatric Vision 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 UnitedHealthcare Vision Network or an out-of-Network Vision Care Provider. To find a UnitedHealthcare Vision Network Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. The Insured Person may also access a listing of UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhcvision.com.

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

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

Policy Deductible

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

What Are the Benefit Descriptions?

Benefits

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

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

Frequency of Service Limits

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

Routine Vision Examination

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

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

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

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

Eyeglass Lenses

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

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

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

Eyeglass Frames

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

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

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

Contact Lenses

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

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

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

Necessary Contact Lenses

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

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

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

Low Vision

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

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive exam of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.
- Low vision aids: Prescribed Medically Necessary optical devices, such as high-power spectacles, magnifiers, and telescopes.
- Low vision follow-up care of four visits in any five year period.

Schedule of Benefits

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

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.

Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - 160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - 200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Low Vision Care Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low vision testing		100% of the billed charge.	75% of the billed charge.
• Low vision therapy		100% of the billed charge.	75% of the billed charge.
• Low vision aids		100% of the billed charge.	75% of the billed charge.
• Low vision follow-up care	Four visits in any 5 year period	100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.

4. Optional Lens Extras not listed in Section 1: Benefits for Pediatric Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:
By mail:
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):
248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

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

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

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

Section 23: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

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

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

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

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

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

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

Copayment and/or Coinsurance Amount

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

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

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

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

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

How do Supply Limits Apply?

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

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

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

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

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

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

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

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

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

Designated Pharmacies

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

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

If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, the Insured will be responsible for the entire cost of the Prescription Drug Product.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, no benefits will be paid for that Prescription Drug Product.

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Do Prior Authorization Requirements Apply?

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

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

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

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

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

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

Prescription Drug Products Substitution Process

The Insured Person and the Insured Person's Physician may request a substitution for a covered prescribed therapy, drug or medication of a covered generic drug if:

- The Insured Person does not tolerate the covered generic drug.
- The Insured Person's Physician determines that the covered generic drug is not therapeutically effective.
- The Insured Person's Physician determines the dosage required for clinically effective treatment differs from the Policy dosage limit.

The Insured's Physician may be required to submit specific clinical documentation as part of the substitution request.

Please call Customer Service at 1-855-828-7716 to request a substitution.

Benefits for Emergency Fill of a Prescription Drug Product

Benefits for an emergency fill of a Prescription Drug Product include no more than the prescribed amount, up to a seven (7) day emergency supply or the minimum packaging size available at the time of the emergency fill of a Prescription Drug Product, when the following criteria apply:

- The dispensing Network Pharmacy cannot reach the Company's pharmacy department by telephone for notification because it is outside of the Company's business hours; or
- The Company's pharmacy department is available to respond to telephone calls from the Network Pharmacy regarding a Covered Medical Expense, but the Company's pharmacy department is not able to reach the prescriber for a full consultation.

Determination as to whether a subsequent fill of the Prescription Drug Product, is a Covered Medical Expense, will be made as part of the Company's notification process.

The Insured Person is responsible for paying the applicable Copayment and/or Coinsurance described in the Schedule of Benefits for an emergency fill of a Prescription Drug Product.

Please access www.uhcsr.com through the Internet or call *Customer Service* at 1-855-828-7716 for a list of medications available for emergency fill.

Coverage of an emergency fill of a Prescription Drug Product is not required if the failure to comply is occasioned by any act of God, bankruptcy, act of government authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

Does Step Therapy Apply?

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

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

When Does the Company Limit Selection of Pharmacies?

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

Coverage Policies and Guidelines

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

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

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. The Prescription Drug List aligns tier placement and Copay value with the overall health care value of the drug. Tiers are the different cost levels of cost-share the Insured Person pays for a medication. Each tier is assigned a cost. This is how much the Insured Person will pay when a prescription is filled. Medications on tier 1 are the Insured Persons lowest-cost options. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to the Insured.

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

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

Rebates and Other Payments

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

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug benefit provision. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to

such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

Definitions

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

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

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

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

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

Exceptions:

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

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

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

Network Pharmacy means a pharmacy that has:

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

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

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

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

PPACA means Patient Protection and Affordable Care Act of 2010.

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

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

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

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

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

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

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

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

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

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

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

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

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

Unproven Service(s) means services, including medications, that are determined not to be effective for the treatment of the medical condition and/or not to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical

evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

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

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

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
4. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
6. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
7. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
8. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
9. Certain unit dose packaging or repackagers of Prescription Drug Products.
10. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
11. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
12. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)
13. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that have been determined to be Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.

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

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product)
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
19. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
20. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
21. Diagnostic kits and products, including associated services.
22. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
23. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.

Right to Request an Exclusion Exception

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

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

Urgent Requests

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

External Review

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

Expedited External Review

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

The Insured Person's Prescription Drug Rights

The Insured Person has the right to safe and effective pharmacy services. The Insured also has the right to know what drugs are covered and the limits that apply. If the Insured Person has a question or concern about their Prescription Drug benefits, please contact the Company, by calling 1-800-767-0700. If the Insured would like to know more about their rights, or if they have concerns about their plan, the Insured may contact the Washington state office of insurance commissioner at 1-800-562-6900 or at www.insurance.wa.gov. If the Insured Person has a concern about the pharmacists or pharmacies serving them, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

Section 24: Assistance and Evacuation Benefits

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

International Students, insured spouse or Domestic Partner and insured minor child(ren) are eligible to receive Assistance and Evacuation Benefits worldwide, except in their Home Country.

Domestic Students, insured spouse or Domestic Partner and insured minor child(ren) are eligible for Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program.

DEFINITIONS

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

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

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

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

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

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

MEDICAL EVACUATION AND REPATRIATION BENEFITS

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

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

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

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

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

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

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

CONDITIONS AND LIMITATIONS

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

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

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

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

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

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

Additional Assistance Services

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

MEDICAL ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

WORLDWIDE DESTINATION INTELLIGENCE

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

global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

TRAVEL ASSISTANCE SERVICES

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

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

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

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

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

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

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

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

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

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

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

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

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

Section 25: Highlights of Services Included with the Student Injury and Sickness Insurance Plan

Healthiest You: 24/7 Doctor Access

Starting on the effective date of your coverage under the student insurance plan, you have 24/7 access to medical advice through HealthiestYou, a national telehealth service*. By visiting www.telehealth4students.com, you have access to board-certified physicians via phone and/or video, where permitted. This service is especially helpful for minor illnesses, such as allergies, sore throat, earache, pink eye, etc. Based on the condition being treated, the doctor can also prescribe certain medications, saving you a trip to the doctor's office. Using HealthiestYou can save you money and time, while avoiding costly trips to a doctor's office, urgent care facility, or emergency room. As an insured with Student Resources, there is no

consultation fee for this service. * Every call with a HealthiestYou doctor is covered 100% during your policy period. You can learn more about this benefit and how to use it in My Account.

This service is meant to complement your Student Health Center. If possible, we encourage you to visit your SHC first before using this service.

HealthiestYou is not health insurance. HealthiestYou is designed to complement, and not replace, the care you receive from your primary care physician. HealthiestYou physicians are an independent network of doctors who advise, diagnose, and prescribe at their own discretion. HealthiestYou physicians provide cross coverage and operate subject to state regulations. Physicians in the independent network do not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. HealthiestYou does not guarantee that a prescription will be written. Services may vary by state.

*Available to Insured students and their covered Dependents; age restrictions may apply. If you call prior to the effective date of your coverage under the insurance plan, you will be charged a service fee before being connected to a board-certified physician.

24/7 Student Assist

Insureds have immediate access to Student Assist, a service that coordinates care using a network of resources. Services available include:

- 24/7 Crisis Support – access to trained master's level specialists, 24/7/365, who provide in-the-moment support and consultation.
- Financial and Legal Counseling – two 30 minute telephonic consultations with money coaches who offer consultations on issues such as financial planning, credit and collection issues, home buying and renting and more. Legal Services are provided by licensed state-specific attorneys. One 30 minute telephonic or face-to-face legal consultation per issue per year at no cost.
- Mediation services – one 30 minute telephonic or face-to-face consultation per issue per year available to help resolve family-related disputes, including but not limited to separation, child custody, child support, divorce property and debt division, etc.
- Living Well Portal – access to liveanworkwell.com where insureds can participate in personalized self-help programs and find information on many helpful resources.
- CollegeLife – direct access to experts on the Optum team and through referrals to a broad spectrum of pre-screened and qualified convenience resources.
- Self Care – access to an evidence-based mobile care solution created by clinical experts that allows insureds to access on-demand help for stress, anxiety, and depression.

Translation services are available in over 170 languages for most services. More information about these services is available by logging into My Account at www.uhcsr.com/MyAccount under Additional Benefits.

HealthiestYou: Virtual Counselor Access

Starting on the effective date of your coverage under the student insurance plan, you have access to mental health providers through a national virtual counseling service. *Psychiatrists, psychologists and licensed therapists are available to you through a variety of communication methods, including phone and video.

When you sign up, you'll complete a questionnaire, choose your provider and select a date and time for your appointment. Appointments are available 7 days a week. Visits are secure, discreet and confidential, and you have ongoing support with the same provider.

As an insured with Student Resources, there is no consultation fee for this service. Every communication with a provider is covered 100% during your policy period.

*Available to Insured students and their covered Dependent; age restrictions may apply, depending on your state.

Schedule of Benefits

Central Washington University
2023-686-1
METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 85.600%
Injury and Sickness Benefits

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

Deductible Preferred Provider	$500 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$1,000 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	60% except as noted below
Out-of-Pocket Maximum Preferred Provider	$5,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$9,000 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$10,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$18,000 (For all Insureds in a Family, Per Policy Year)

The Coinsurance amount is the percentage of Covered Medical Expenses that the Company pays. For the Covered Medical Expenses listed in the Schedule of Benefits, benefits will be paid at the Coinsurance amount stated above, unless otherwise specifically stated.

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** network for this plan is Choice.

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

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

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

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

The flight exclusion will be waived and benefits will be paid for Covered Medical Expenses incurred for students while participating in a school sponsored flight program.

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

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Intensive Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Miscellaneous Expenses	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Routine Newborn Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50%, per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50%, per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Registered Nurse's Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50%, per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Day Surgery Miscellaneous	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50% per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physiotherapy Limits per Policy Year as follows: 10 visits of manipulative therapy 25 visits of any combination of physical therapy, occupational therapy, and speech therapy Separate physical, occupational and speech therapy limits apply to rehabilitative and Habilitative Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$200 Copay per visit 100% of Allowed Amount after Deductible	$200 Copay per visit 100% of billed charges after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Diagnostic X-ray Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Radiation Therapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Laboratory Procedures	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Tests & Procedures	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Injections	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Chemotherapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit for additional information. No Deductible, Copays, or Coinsurance will be applied to contraceptives covered under the Preventive Care Services benefit. The total amount an Insured is required to pay for a covered insulin Prescription Drug will not exceed $35 per 30-day supply. Insulin Prescription Drugs will be covered without being subject to a Deductible and any Copay and/or Coinsurance paid by the Insured will be applied toward the Insured's Deductible.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $15 Copay per prescription Tier 1 $35 Copay per prescription Tier 2 $100 Copay per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	$15 Copay per prescription generic drug $35 Copay per prescription brand-name drug 50% of billed charge up to a 31-day supply per prescription not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Durable Medical Equipment	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Consultant Physician Fees	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Dental Injury Benefits paid on Injury to Sound, Natural Teeth only.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Dental Treatment	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Mental Illness Treatment See Benefits for Mental Disorders and Substance Use Disorders	**Inpatient:** 80% of Allowed Amount after Deductible **Outpatient office visits:** 80% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 80% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Substance Use Disorder Treatment See Benefits for Mental Disorders and Substance Use Disorders	**Inpatient:** 80% of Allowed Amount after Deductible **Outpatient office visits:** 80% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 80% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Allowed Amount after Deductible
Maternity	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Complications of Pregnancy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	60% of Allowed Amount after Deductible
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Diabetes Services See Benefits for Diabetes	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Home Health Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospice Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Inpatient Rehabilitation Facility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Skilled Nursing Facility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Urgent Care Center	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Approved Clinical Trials	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Transplantation Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Acupuncture Services 30 visits maximum per Policy Year	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Genetic Testing	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Infertility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Medical Foods See also Benefits for Phenylketonuria Treatment and Eosinophilic Gastrointestinal Associated Disorder	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Neurodevelopmental Therapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Nutritional Counseling	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

UnitedHealthcare®

Your Rights and Protections Against Surprise Medical Bills and Balance Billing In Washington State

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or on request, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, and providers must tell you which provider networks they participate in on their website or on request.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in- network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals and air ambulance providers, can **never** require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are **never** required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at their website or by calling 1-800-562- 6900.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit the Office of the Insurance Commissioner Balance Billing Protection Act website for more information about your rights under Washington state law.

NON-DISCRIMINATION NOTICE

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

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

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

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

If you believe that the Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can also file a grievance by writing my mail or by phone:

Washington State Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255
Phone: 1-800-562-6900 or (360) 725-7080

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

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

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

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

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

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

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

LANGUAGE ASSISTANCE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

Cherokee
ᏕᎶᏂᎯᏍᏗ ᎤᎾᏝᏍᎦᏍᏗ ᎤᎾᏝᏡᎬᎢ ᏂᎯ ᏒᏣᏛᎩᎢᏍᏓᏁᎸᎢ ᏂᏝᎨᏩᏛᎾ ᎠᏎᏍᎢ. ᎰᏩ ᎠᏂ ᎾᏏᎳᏛᏕ 1-866-260-2723.

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

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho̱ chi apela hinla. I paya 1-866-260-2723.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Karen
usdmw>rRpXRt*D>erRM>tDRoh0J vXwvd.h.tyORb. (cDvD) M.vDRI 0Ho;plRqJ;usd;b. 1-866-260-2723 wuh>I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Syriac- Assyrian
ܚܕܡܬ̈ܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܨܛܝܪܝܢܬܐ، ܐܝܬ ܡܛܝܐ ܠܘܬܘܟ݂ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

Tagalog

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

Telugu
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి.

దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข
1-866-260-2733

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

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

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

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

Urdu

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

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

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

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