

# UNITEDHEALTHCARE INSURANCE COMPANY

## BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE PPO PLAN

### CERTIFICATE OF COVERAGE

Designed Especially for the International Students of

**SCAD – Savannah College of Art and Design**

2019-2020

#### **This Certificate of Coverage is Part of Policy # 2019-202924-4**

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

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

**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.**



## Table of Contents

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Introduction.....	1
Section 1: Who Is Covered .....	1
Section 2: Effective and Termination Dates.....	2
Section 3: Extension of Benefits after Termination .....	2
Section 4: Pre-Admission Notification .....	2
Section 5: Preferred Provider Information.....	2
Section 6: Medical Expense Benefits – Injury and Sickness .....	3
Section 7: Mandated Benefits .....	9
Section 8: Accidental Death and Dismemberment Benefits .....	15
Section 9: Definitions .....	15
Section 10: Exclusions and Limitations.....	19
Section 11: How to File a Claim for Injury and Sickness Benefits .....	20
Section 12: General Provisions.....	21
Section 13: Notice of Appeal Rights .....	22
Section 14: Online Access to Account Information .....	30
Section 15: Important Company Contact Information .....	30
Additional Policy Documents	
Schedule of Benefits .....	Attachment
Pediatric Dental Services Benefits .....	Attachment
Pediatric Vision Services Benefits .....	Attachment
UnitedHealthcare Pharmacy (UHCP) and Out-of-Network Prescription Drug Benefits.....	Attachment
Mandatory Offer Endorsement – Morbid Obesity Treatment .....	Attachment
Assistance and Evacuation Benefits.....	Attachment

## Introduction

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

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

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

To receive the highest level of benefits from the plan, the Insured Person should obtain covered services from Preferred Providers whenever possible. The easiest way to locate Preferred Providers is through the plan’s web site at [www.uhcsr.com/scad](http://www.uhcsr.com/scad). The web site will allow the Insured to easily search for providers by specialty and location.

The Insured may also call the Customer Service Department at 1-866-948-8472, toll free, for assistance in finding a Preferred Provider.

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-866-948-8472. The Insured can also write to the Company at:

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

## Section 1: Who Is Covered

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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 International students are automatically enrolled in this insurance plan at registration. OPT students may be enrolled in this plan on a voluntary basis.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student’s legal spouse and dependent children under 26 years of age.

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.
  - 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**

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The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2019. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 31, 2020. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

## **Section 3: Extension of Benefits after Termination**

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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 payable 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**

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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 1-866-948-8472.

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

## **Section 5: Preferred Provider Information**

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

UnitedHealthcare Choice Plus

The availability of specific providers is subject to change without notice. A list of Preferred Providers is located on the plan's web site at [www.uhcsr.com/scad](http://www.uhcsr.com/scad). Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-866-948-8472 and/or by asking the provider when making an appointment for services.

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

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

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

### **Inpatient Expenses**

**Preferred Providers** – Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-866-948-8472 for information about Preferred Hospitals.

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

### **Outpatient Hospital Expenses**

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

### **Professional & Other Expenses**

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

## **Section 6: Medical Expense Benefits – Injury and Sickness**

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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.

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

### **Inpatient**

1. **Room and Board Expense.**  
Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.
2. **Intensive Care.**  
If provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses.**  
When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Benefits will be paid for services and supplies such as:

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

4. **Routine Newborn Care.**  
While Hospital Confined and routine nursery care provided immediately after birth. See Benefits for Postpartum Care.
5. **Surgery.**  
Physician's fees for Inpatient surgery.
6. **Assistant Surgeon Fees.**  
Assistant Surgeon Fees in connection with Inpatient surgery.
7. **Anesthetist Services.**  
Professional services administered in connection with Inpatient surgery.
8. **Nurse's Services.**  
Nurse's services which are all of the following:
  - Private duty nursing care only.
  - Received when confined as an Inpatient.
  - Ordered by a licensed Physician.
  - A Medical Necessity.

General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.
9. **Physician's Visits.**  
Non-surgical Physician services when confined as an Inpatient.
10. **Pre-admission Testing.**  
Benefits are limited to routine tests such as:
  - Complete blood count.
  - Urinalysis.
  - Chest X-rays.

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

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

## **Outpatient**

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

16. **Physiotherapy.**  
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
  - Occupational therapy.
  - Cardiac rehabilitation therapy.
  - Manipulative treatment.
  - Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from injury, trauma, stroke, surgery, cancer, or vocal nodules.
17. **Medical Emergency Expenses.**  
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
- The facility charge for use of the emergency room and supplies.
- All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.
18. **Diagnostic X-ray Services.**  
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.
19. **Radiation Therapy.**  
See Schedule of Benefits.
20. **Laboratory Procedures.**  
Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
21. **Tests and Procedures.**  
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
  - Physiotherapy.
  - X-rays.
  - Laboratory Procedures.
- The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
  - Infusion therapy.
  - Pulmonary therapy.
  - Respiratory therapy.
  - Dialysis and hemodialysis.
- Tests and Procedures for preventive care are provided as specified under Preventive Care Services.
22. **Injections.**  
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.
23. **Chemotherapy.**  
See Schedule of Benefits.
24. **Prescription Drugs.**  
See Schedule of Benefits. Benefits will not be denied for prescription inhalants required to enable an Insured Person to breathe when suffering from asthma or other life-threatening bronchial ailments based upon any restriction on the number of days before an inhaler refill may be obtained if ordered or prescribed by a Physician.

## Other

25. **Ambulance Services.**

See Schedule of Benefits.

26. **Durable Medical Equipment.**

Durable Medical Equipment must be all of the following:

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

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

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

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

27. **Consultant Physician Fees.**

Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**

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

- Injury to Sound, Natural Teeth.
- Surgical removal of impacted teeth.
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that would lead to functional impairments.

Benefits will also be paid the same as any other Injury or Sickness for facility and general anesthesia charges for dental care provided to:

- An Insured who is age 7 or younger or who is developmentally disabled.
- An Insured for whom a successful result cannot be expected by local anesthesia due to a neurological disorder.
- An Insured who has sustained extensive facial or dental trauma.

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

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

29. **Mental Illness Treatment.**

Benefits will be paid for services received:

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

30. **Substance Use Disorder Treatment.**

Benefits will be paid for services received:

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

Services may be received in a Hospital licensed in Georgia that specializes in the treatment of alcoholics or drug addicts and that is operated primarily for the treatment of such persons.



31. **Maternity.**  
Same as any other Sickness. See also Benefits for Postpartum Care.
32. **Complications of Pregnancy.**  
Same as any other Sickness.
33. **Preventive Care Services.**  
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the *United States Preventive Services Task Force*.
  - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
  - With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
  - With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
34. **Reconstructive Breast Surgery Following Mastectomy.**  
Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Mastectomy.
35. **Diabetes Services.**  
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for the Management and Treatment of Diabetes.
36. **Home Health Care.**  
Services received from a licensed home health agency that are:
- Ordered by a Physician.
  - Provided or supervised by a Registered Nurse in the Insured Person’s home.
  - Pursuant to a home health plan.
- Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.
37. **Hospice Care.**  
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.
- Hospice care includes:
- Physical, psychological, social, and spiritual care for the terminally ill Insured.
  - Short-term grief counseling for immediate family members while the Insured is receiving hospice care.
38. **Inpatient Rehabilitation Facility.**  
Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.
39. **Skilled Nursing Facility.**  
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.
  - Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.
40. **Urgent Care Center.**  
Benefits are limited to:
- The facility or clinic fee billed by the Urgent Care Center.

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

41. **Hospital Outpatient Facility or Clinic.**

Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

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

42. **Approved Clinical Trials.**

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

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the Policy. Routine patient care costs do not include:

- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

See also Benefits for Drug Treatment of Children's Cancer.

43. **Transplantation Services.**

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

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

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

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

44. **Pediatric Dental and Vision Services.**

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

45. **Breast Reduction Surgery.**

When Medically Necessary and when the following criteria are met:

- The Company determines that the surgery is performed to treat a physiologic functional impairment.
- The surgery is not determined to be for cosmetic purposes only.

46. **Child Wellness Services.**  
Preventive services for Insured Dependents age 5 and under.

Benefits are limited to:

- Age appropriate immunizations.
- Development assessment of the Dependent.
- Laboratory testing.
- Periodic health assessments.

47. **Medical Foods.**  
Benefits for enteral formulas, nutritional supplements and low protein modified foods for use at home as Medically Necessary and ordered by a Physician for the therapeutic treatment of an inherited metabolic disease such as Phenylketonuria (PKU).

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

48. **Medical Supplies.**  
Medical supplies must meet all of the following criteria:
- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
  - Used for the treatment of a covered Injury or Sickness.

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

49. **Nutritional Counseling.**  
Benefits for Medically Necessary nutritional counseling for obesity limited to four (4) visits per Policy Year.

50. **Ostomy Supplies.**  
Benefits for ostomy supplies are limited to the following supplies:
- Pouches, face plates and belts.
  - Irrigation sleeves, bags and ostomy irrigation catheters.
  - Skin barriers.

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

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

## **Section 7: Mandated Benefits**

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### **BENEFITS FOR MAMMOGRAPHY**

Benefits will be paid the same as any other Sickness for a mammogram subject to all of the terms and conditions of the policy and according to the following guidelines:

1. Once as a baseline mammogram for any female who is at least 35 but less than 40 years of age;
2. Once every two years for any female who is at least 40 but less than 50 years of age;
3. Once every year for any female who is at least 50 years of age; and
4. When ordered by a Physician for a female at risk.

For purpose of this benefit, "Female at risk" means a woman:

1. Who has a personal history of breast cancer;
2. Who has a personal history of biopsy proven benign breast disease;
3. Whose grandmother, mother, sister, or daughter has had breast cancer; or
4. Who has not given birth prior to the age of 30.

Reimbursement will be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by the state of Georgia.

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

### **BENEFITS FOR PAP SMEARS**

Benefits will be paid the same as any other Sickness for an annual "Pap smear" or "Papanicolaou smear" examination for the purpose of detecting cancer, or more frequently if ordered by a Physician. The examination must be performed in accordance with standards established by the American College of Pathologists.

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

### **BENEFITS FOR PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS**

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) test to detect the presence of prostate cancer. The test will be covered on an annual basis for an Insured males who is 45 years of age or older. The test will also be covered for an Insured male 40 years of age or older, when ordered by a Physician. All tests must be performed in accordance with standards established by the American College of Pathologists.

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

### **BENEFITS FOR CHLAMYDIA SCREENING**

Benefits will be paid the same as any other Sickness for one annual chlamydia screening test for each Insured Person. "Chlamydia screening test" means any laboratory test of the urogenital tract which specifically detects for infection by one or more agents of chlamydia trachomatis and which test is approved for such purposes by the federal Food and Drug Administration.

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

### **BENEFITS FOR MASTECTOMY**

Benefits will be paid the same as any other Sickness for a mastectomy including breast reconstructive surgery of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas, and at least two external postoperative prostheses incidental to the covered mastectomy. Coverage will be provided in a manner determined in consultation with the attending Physician.

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

### **BENEFITS FOR BONE MASS MEASUREMENT**

Benefits will be paid the same as any other Sickness for Qualified Insured Persons for scientifically proven Bone Mass Measurement (bone density testing) for the prevention, diagnosis, and treatment of osteoporosis.

1. "Bone mass measurement" means a radiologic or radioisotopic procedure or other technologies approved by the United States Food and Drug Administration and performed on an individual for the purpose of identifying bone mass or detecting bone loss.
2. "Qualified Insured Person" means an:
  - a. Estrogen-deficient woman or individual at clinical risk of osteoporosis as determined directly or indirectly by a physician and who is considering treatment;
  - b. Individual with osteoporotic vertebral abnormalities;
  - c. Individual receiving long-term glucocorticoid (steroid) therapy;
  - d. Individual with primary hyperparathyroidism; or
  - e. Individual being monitored directly or indirectly by a physician to assess the response to or efficacy of approved osteoporosis drug therapies.

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

### **BENEFITS FOR COLORECTAL CANCER SCREENING**

Benefits will be paid the same as any other Sickness for colorectal cancer screening, examinations and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, for the ages, family histories, and frequencies referenced in such guidelines and recommendations and deemed appropriate by the attending physician after conferring with the patient.

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

### **BENEFITS FOR DENTAL ANESTHESIA**

Benefits will be provided for general anesthesia and associated hospital and ambulatory surgical facility charges in conjunction with dental care provided to an Insured, if such person is:

1. Seven years of age or younger or is developmentally disabled;
2. An individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the Insured; or
3. An individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

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

### **BENEFITS FOR THE MANAGEMENT AND TREATMENT OF DIABETES**

Benefits will be provided for all Covered Medical Expenses related to the medically appropriate and necessary medical equipment, supplies, pharmacologic agents, and outpatient self-management training and education, including medical nutrition therapy, for an Insured Person with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a Physician.

"Pharmacologic agents" include:

1. Insulin of each class approved by the federal Food and Drug Administration (FDA) including formulations available either in a vial or cartridge;
2. Prescription insulin of each class approved by the FDA including formulations available either in a vial or cartridge formulation;
3. Prescription oral medications of each class approved by the FDA for the management of diabetes;
4. Oral products approved by the FDA for the management of diabetes;
5. Glucagon kits; and Pharmacologic agents approved by the FDA for the management of diabetes and its complications.

"Medical equipment" includes the following medical equipment, non-disposable and durable medical equipment when prescribed by a Physician:

1. Blood glucose monitors and glucose monitors, including commercially available blood glucose monitors;
2. Blood glucose monitors and glucose monitors for the legally blind or visually impaired due to diabetes, including commercially available blood glucose monitors with adaptive devices for the blind;
3. Injection aids, including those adaptable to meet the needs of the legally blind, to assist with insulin injection;
4. Insulin pumps, which includes insulin infusion pumps;
5. Medical supplies for use with or without insulin pumps and insulin infusion pumps, including durable devices to assist with the injection of insulin and infusion sets;
6. Therapeutic shoes, custom fitted inserts and related orthopedic footwear associated with the prevention and treatment of diabetes and diabetes related complications;
7. Pen-like insulin injection devices designed for multiple use;
8. Lancing devices associated with the drawing for blood samples for use with blood glucose monitors; and
9. Other medical equipment, non-disposable and durable medical equipment that is Medically Necessary and consistent with the current standards of care of the American Diabetes Association.

"Supplies" means the following single-use medical supplies when prescribed by a Physician:

1. Test strips for glucose monitors, which include test strips whose performance achieved clearance by the FDA;
2. Visual reading and urine testing strips, which includes visual reading strips for glucose, urine testing strips for ketones, or urine test strips for both glucose and ketones;
3. Lancets and single use lancing devices used in conjunction with the monitoring of glycemic control;
4. Syringes, which includes insulin syringes, insulin injection needles for use with pen-like insulin injection devices and other disposable parts required for insulin injection aids;
5. Medical supplies for use with insulin pumps and insulin infusion pumps to include disposable devices to assist with the injection of insulin and infusion sets, alcohol swabs and related preparations and other similar compounds associated with the cleansing of injection sites prior to the administration of insulin; and

6. Such other single-use medical supplies that are Medically Necessary and consistent with the current standards of care of the American Diabetes Association.

Diabetes self-management training and medical nutrition therapy services must be prescribed by a Physician. The diabetes self-management training program must be:

1. Provided under a training program that is recognized by the federal Centers for Medicare & Medicaid services (CMS); or
2. Approved, accredited or certified by a national organization assessing standards of quality in the provision of diabetes self-management education.

Diabetes self-management training programs shall be provided when the following criteria are met:

1. Upon a Physician's diagnosis that the Insured Person has diabetes;
2. Upon a significant change in an Insured Person's diabetes related condition;
3. Upon a change in an Insured Person's diagnostic levels;
4. Upon a change in treatment regimen;
5. Upon an Insured Person's initiation of insulin therapy;
6. Upon identification of inadequate diabetes control as evidenced by diagnostic laboratory tests falling outside of acceptable ranges;
7. Upon determination that an Insured Person is at high risk for complications based on inadequate glycemic control documented by acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the Insured Person's history during which the insured Person needed emergency room visits or hospitalization;
8. Upon determination that an Insured Person is at high risk based on at least one of the documented diabetes related complications, including:
  - a. Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation;
  - b. Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye;
  - c. Kidney complications related to diabetes, when manifested by albuminuria without other cause, or elevated creatinine.

Medical nutrition therapy services shall be provided in addition to diabetes self-management training when the following are met:

1. Upon a Physician's diagnosis that an Insured Person has diabetes;
2. Upon a significant change in an Insured Person's diabetes related condition;
3. Upon a change in an Insured Person's diagnostic levels;
4. Upon a change in treatment regimen;
5. Upon an Insured Person's initiation of insulin therapy;
6. Upon identification of inadequate diabetes control as evidenced by diagnostic laboratory tests falling outside of acceptable ranges;
7. Upon determination that an Insured Person is at high risk for complications based on inadequate glycemic control documented by acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the Insured Person's history during which the insured Person needed emergency room visits or hospitalization;
8. Upon determination that an Insured Person is at high risk based on at least one of the documented diabetes related complications, including:
  - a. Lack of feeling in the foot or other foot complications such as foot ulcers, deformities, or amputation;
  - b. Pre-proliferative or proliferative retinopathy or prior laser treatment of the eye;
  - c. Kidney complications related to diabetes, when manifested by albuminuria without other cause, or elevated creatinine.

Instructions in diabetes self-management training shall be provided by a healthcare professional who is either: (1) a certified diabetes educator; and/or (2) a certified, registered or licensed health professional with expertise in diabetes satisfying criteria for Medicare coverage for diabetes education and training pursuant to 42 CFR Part 410. Instruction in medical nutrition therapy shall be provided by a healthcare professional who is either: (1) a registered dietitian; and/or (2) a certified, registered, or licensed health professional with expertise in medical nutrition therapy satisfying criteria for Medicare coverage for medical nutrition therapy pursuant to 42 CFR Part 410.

Primary or initial diabetes self-management training and medical nutrition therapy services shall be provided in group settings for a total of 10 hours in the initial year after diagnosis unless the following criteria are met: (1) a group session is not available within two months of the date diabetes self-management training or medical nutrition therapy are ordered; or (2) the Insured Person's Physician documents that the Insured Person has special needs that will hinder effective participation in a group training session. Secondary or follow-up diabetes self-management training and medical nutrition therapy shall be provided during individual patient meetings or sessions within the first twelve months after a primary or initial diabetes self-management training or medical nutrition therapy group session.

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

#### **BENEFITS FOR SURVEILLANCE TESTS FOR OVARIAN CANCER**

Benefits will be paid the same as any other Sickness for surveillance tests for ovarian cancer for an Insured Person age 35 and older at risk for ovarian cancer.

At risk for ovarian cancer means having a family history: with one or more first or second degree relatives with ovarian cancer; of clusters of women relatives with breast cancer; of nonpolyposis colorectal cancer; or testing positive for BRCA1 or BRCA2 mutations.

Surveillance tests means annual screening using: CA-125 serum tumor marker testing, transvaginal ultrasound and pelvic examination.

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

#### **BENEFITS FOR TELEMEDICINE**

Benefits will be paid the same as any other Sickness for Telemedicine as for services received on a face-to-face basis. "Telemedicine" means the practice, by a duly licensed Physician or other health care provider acting within the scope of such provider's practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient. Standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof do not constitute telemedicine services.

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

#### **BENEFITS FOR DRUG TREATMENT OF CHILDREN'S CANCER**

Benefits will be paid the same as any other Sickness for routine patient care costs incurred in connection with the provision of goods or services to Dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those children who are enrolled in an approved clinical trial program for treatment of children's cancer and are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.

"Approved clinical trial program for treatment of children's cancer" means a Phase II and III prescription drug clinical trial program in this state, as approved by the federal Food and Drug Administration or the National Cancer Institute for the treatment of cancer that generally first manifests itself in children under the age of 19. Such program must: (i) test new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in children; (ii) introduce a new therapy or regimen to treat recurrent cancer in children; or (iii) seek to discover new therapies or regimens for the treatment of cancer in children which are more cost effective than standard therapies or regimens. Such program must be certified by and utilize the standards for acceptable protocols established by the Pediatric Oncology Group or Children's Cancer Group.

"Routine patient care costs" means those medically necessary costs of blood tests, X-rays, bone scans, magnetic resonance images, patient visits, hospital stays, or other similar costs generally incurred by the insured party in connection with the provision of goods, services, or benefits to dependent children under an approved clinical trial program for treatment of children's cancer which otherwise would be covered under the supplemental medical accident and sickness insurance benefit plan, policy, or contract if such medically necessary costs were not incurred in connection with an approved clinical trial program for treatment of children's cancer. Routine patient care costs specifically shall not include the costs of any clinical trial therapies, regimens, or combinations thereof, any drugs or pharmaceuticals, any costs associated with the provision of any goods, services, or benefits to dependent children which generally are furnished without charge in connection with such an approved clinical trial program for treatment of children's cancer, any additional costs associated with the provision of any goods, services, or benefits which previously have been provided to the Dependent child, paid for, or reimbursed, or any other similar costs.

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

#### **BENEFITS FOR BONE MARROW TRANSPLANTS**

Benefits will be paid the same as any other Sickness for bone marrow transplants.

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

### **BENEFITS FOR POSTPARTUM CARE**

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

Any decisions to shorten the length of stay to less than the minimum specified above shall be made by the attending Physician, obstetrician, or certified nurse midwife after conferring with the mother. If a mother and her newborn are discharged prior to the minimum inpatient stay length specified above, then coverage shall be provided for up to two follow-up visits, provided that the first visit shall occur within 48 hours after discharge. Such visits shall be conducted by a Physician, a physician assistant, or a registered professional nurse with experience and training in maternal and child health nursing.

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

### **BENEFITS FOR TREATMENT OF BURNS**

Benefits will be paid the same as any other Sickness for the treatment of burns using skin substitutes utilizing cryopreserved cadaver derived skin tissue.

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

### **BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS**

Benefits will be paid for prescribed, orally administered anticancer medications on a basis that is no less favorable than intravenously administered or injected chemotherapy.

The total Copayment and Coinsurance an Insured Person is required to pay shall not exceed \$200 for an individual prescription of up to a 31-day supply per prescription.

Benefits shall be subject to all Deductible, limitations, and any other provision of the Policy.

### **BENEFITS FOR HEARING AIDS FOR INSUREDS AGE 18 AND YOUNGER**

Benefits will be provided for the billed charges for one Hearing Aid per hearing impaired ear not to exceed \$3,000.00 per Hearing Aid for Insureds 18 years of age or under. Such benefits include the replacement for one Hearing Aid per hearing impaired ear every 48 months for Insureds 18 years of age or under.

In the event that a Hearing Aid or aids cannot adequately meet the needs of the Insured, and the Hearing Aid or aids cannot be adequately repaired or adjusted, the Hearing Aid or aids replacement will be covered. Coverage for the replacement shall be offered within two (2) months from the date it is determined that the Hearing Aid or aids cannot be repaired or adjusted.

Benefits include Medically Necessary services and supplies, including the initial Hearing Aid evaluation, fitting, dispensing, programming, servicing, repairs, follow-up maintenance, adjustments, ear molds, ear mold impressions, auditory training, and probe microphone measurements to ensure appropriate gain and output, as well as verifying benefit from the system selected according to accepted professional standards. Such services shall be covered on a continuous basis, as needed, during each 48 month period not to exceed the \$3,000 per hearing impaired ear benefit or for the duration of the Hearing Aid warranty, whichever time period is longer.

The Insured may choose:

1. a higher priced Hearing Aid or aids and pay the difference between the price of the Hearing Aid or aids and the \$3,000 available benefit.
2. to purchase his or her Hearing Aid or aids through any licensed audiologist or licensed hearing aid dealer or dispenser in the state of Georgia.

Hearing Aid means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired human hearing that is worn in or on the body. The term "hearing aid" includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, nonimplanted bone anchored hearing aids, nonimplanted bone conduction Hearing Aids, and frequency modulation systems. Personal sound amplification products shall not qualify as Hearing Aids.



Benefits shall be subject to all Deductibles, Coinsurance, Copayments, limitations, and any other provision of the Policy.

## **Section 8: Accidental Death and Dismemberment Benefits**

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### **Loss of Life, Limb or Sight**

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

#### **For Loss of**

Life	\$10,000.00
Two or More Members	\$10,000.00
One Member	\$ 5,000.00
Thumb or Index Finger	\$ 2,500.00

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 9: Definitions**

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

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

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

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

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

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

**CUSTODIAL CARE** means services that are any of the following:

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

**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 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 disability or physical disability as determined by the Department of Behavioral Health and Developmental Disabilities.
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 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 handicapped as defined by subsections (1) and (2).

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

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

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

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

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

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

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

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

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

1. Directly and independently caused by specific accidental contact with another body or object.
2. Unrelated to any pathological, functional, or structural disorder.
3. A source of loss.
4. Treated by a Physician within 30 days after the date of accident.
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 the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

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

**NEWBORN INFANT** means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 31 days after birth. A newly born child of the Insured shall include an adopted child. The coverage for the adopted child shall be effective from the date of placement for adoption or final decree of adoption, whichever occurs first. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital

defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

**NURSE** means a Registered Nurse (R.N.) who is not a member of the Insured Person's immediate family; or, when a Registered Nurse is not available and upon the recommendation of the attending Physician, a Licensed Practical Nurse (L.P.N.) who is not a member of the Insured Person's immediate family.

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

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

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

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

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

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

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

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

**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.

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

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

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

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

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

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

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

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

## **Section 10: Exclusions and Limitations**

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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. Cosmetic procedures, except reconstructive procedures to correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
3. 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.
4. Dental treatment, except:
  - For accidental Injury to Sound, Natural Teeth.
  - As described under Dental Treatment in the Policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
5. Elective Surgery or Elective Treatment.
6. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
7. Foot care for the following:
  - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
8. Health spa or similar facilities. Strengthening programs.
9. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

  - Hearing defects or hearing loss as a result of an infection or Injury.
  - Hearing Aids as specifically provided in the Benefits for Hearing Aids for Insureds Age 18 and Younger.
10. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
12. Injury sustained while:
  - Participating in any intercollegiate or professional sport, contest or competition.
  - Traveling to or from such sport, contest or competition as a participant.
  - Participating in any practice or conditioning program for such sport, contest or competition.
13. Investigational services.
14. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
15. Prescription Drugs, services or supplies as follows:
  - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
  - Immunization agents, except as specifically provided in the Policy.
  - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the Policy.
  - Products used for cosmetic purposes.
  - Drugs used to treat or cure baldness. Anabolic steroids used for body building.

- Anorectics - drugs used for the purpose of weight control.
  - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
  - Growth hormones.
  - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
16. Reproductive/Infertility services including but not limited to the following:
- Procreative counseling.
  - Genetic counseling and genetic testing.
  - Cryopreservation of reproductive materials. Storage of reproductive materials.
  - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose or treat the underlying cause of the infertility.
  - Premarital examinations.
  - Impotence, organic or otherwise.
  - Female sterilization procedures, except as specifically provided in the Policy.
  - Vasectomy.
  - Reversal of sterilization procedures.
17. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
18. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses.
- This exclusion does not apply as follows:
- When due to a covered Injury or disease process.
  - To benefits specifically provided in Pediatric Vision Services.
  - To lenses following surgical removal of the lenses of the eye.
19. Preventive care services which are not specifically provided in the Policy, including:
- Routine physical examinations and routine testing.
  - Preventive testing or treatment.
  - Screening exams or testing in the absence of Injury or Sickness.
20. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
21. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury.
22. Speech therapy, except as specifically provided in the Policy.
23. Supplies, except as specifically provided in the Policy.
24. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
25. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
26. 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).

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

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In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the college under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

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

## Section 12: General Provisions

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

**CLAIM FORMS:** Claim forms are not required.

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

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

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

Upon receipt of due written or electronic proof of loss, the Company will have 15 working days for electronically submitted claims and 30 calendar days for paper claims to mail the Insured a letter or send an electronic notice which states the reasons the Company may have for failing to pay the claim, either in whole or in part, and which also gives the Insured a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, the Company will then have 15 working days for electronically submitted claims and 30 calendar days for paper claims to process and either pay the claim or deny it, in whole or part, giving the Insured the reasons for denying such claim or any portion thereof.

For failure to comply with the requirements of this provision, the Company will pay interest to the Insured equal to 12% per annum on the proceeds or benefits due under the terms of the Policy.

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

**LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proofs of loss have been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of 3 years after the time written proofs of loss are required to be furnished.

**RIGHT OF RECOVERY FROM THIRD PARTIES:** If an Insured has a claim for damages or a right to recover damages from a third party or parties for any Sickness or Injury for which benefits are payable under the Policy, the Company may have a right of recovery. The right of recovery shall be limited to the recovery of any benefits paid for identical Covered Medical Expenses under the Policy, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. The Company's right of recovery may include compromise settlements. The Insured or their attorney must inform the Company of any legal action or settlement agreement at least ten days prior to settlement or trial. The Company will then notify the Insured of the amount it seeks to recover for Covered Medical Expenses paid. The Company's recovery may be reduced by the pro-rata share of the Insured's attorney's fees and expenses of litigation.

**RIGHT OF RECOVERY FROM OVERPAYMENTS:** 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.

## **Section 13: Notice of Appeal Rights**

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### **RIGHT TO INTERNAL APPEAL**

#### **Standard Internal Appeal**

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 1-866-948-8472 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

#### **Internal Appeal Process**

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

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

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

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

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

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

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

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

1. For a Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 60 days after the Company's receipt of the grievance.

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

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

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;



2. Information sufficient to identify the claim involved in the grievance, including the following:
  - a. The date of service;
  - b. The name health care provider; and
  - c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
  - a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
  - b. Reference to the specific Policy provisions upon which the determination is based;
  - c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
  - d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
  - e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
  - f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

### **Expedited Internal Review**

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

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

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

To request an Expedited Internal Appeal, please contact Claims Appeals at 1-888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

### **Expedited Internal Review Process**

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

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

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

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

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

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or

2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

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

#### **RIGHT TO EXTERNAL INDEPENDENT REVIEW**

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

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Company. Upon request of an External Review, the Company shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

#### **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  
1-888-315-044

#### **Standard External Review (SER) Process**

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

1. Within 5 business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
  - a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
  - b. The Insured Person has exhausted the Company's Internal Appeal Process;
  - c. The Insured Person has provided all the information and forms necessary to process the request; and
  - d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
  - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
  - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
3. After receiving notice that a request is eligible for SER, the Commissioner shall, within 1 business day:
  - a. Assign an Independent Review Organization (IRO) from the Commissioner's approved list;
  - b. Notify the Company of the name of the assigned IRO; and

- c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4.
  - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
  - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
  - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
  - b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
  - c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

#### **Expedited External Review (EER) Process**

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

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the 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 gain 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 gain maximum function; or
    - The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

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

2. Upon receipt of a request for an EER, the Company shall immediately review the request to determine that:
  - a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
  - b. The Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sub-sections 1. a. and b. shown above;
  - c. The Insured Person has provided all the information and forms necessary to process the request; and
  - d. The service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
3. Immediately after completion of the review, the Company shall notify the Commissioner, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
  - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;

- b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an Independent Review Organization (IRO) from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
  - a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
  - b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
5.
  - 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.
  - a. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
6. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
  - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
  - b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.
7. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

#### **Standard Experimental or Investigational Treatment External Review (SEIER) Process**

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

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Company.
2. Within 5 business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
  - a. The individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
  - b. The recommended or requested health care services or treatment:
    - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
    - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
  - c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
    - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
    - Standard health care services or treatments are not medically appropriate for the Insured Person;
    - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
  - d. The Insured Person's treating Physician:
    - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
    - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
  - e. The Insured Person has exhausted the Company's Internal Appeal Process; and
  - f. The Insured Person has provided all the information and forms necessary to process the request.

3. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
  - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
  - b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within 1 business day:
  - a. Assign an IRO from the Commissioner's approved list;
  - b. Notify the Company of the name of the assigned IRO; and
  - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
5.
  - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SEIER.
  - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
  - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
  - b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
  - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
8. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

#### **Expedited Experimental or Investigational Treatment External Review (EEIER) Process**

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

1. An Insured Person or an Authorized Representative may make an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the 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 denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or
  - b. A Final Adverse Determination, if:
    - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
    - The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

An EEIER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
2. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:

- a. The individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
  - b. The recommended or requested health care services or treatment:
    - Is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
    - Is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
  - c. The Insured Person's treating Physician has certified that one of the following situations is applicable:
    - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
    - Standard health care services or treatments are not medically appropriate for the Insured Person;
    - There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
  - d. The Insured Person's treating Physician:
    - Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
    - Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
  - e. The Insured Person has exhausted the Company's Internal Appeal Process unless the Insured person is not required to do so as specified in sub-sections 1. a. and b. above; and
  - f. The Insured Person has provided all the information and forms necessary to process the request.
3. The Company shall immediately notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
    - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
    - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
  4. After receiving notice that a request is eligible for EEIER, the Commissioner shall immediately:
    - a. Assign an IRO from the Commissioner's approved list; and
    - b. Notify the Company of the name of the assigned IRO.
  5. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
  6.
    - a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
    - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
  7.
    - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the EEIER.
    - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
  8. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
  9. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
    - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
    - b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
    - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.

10. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 5 calendar days after being selected by the IRO.
11. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
12. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

#### **BINDING EXTERNAL REVIEW**

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

#### **APPEAL RIGHTS DEFINITIONS**

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

##### **Adverse Determination** means:

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 1-866-948-8472 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, or to file a complaint, your state department of insurance may be able to assist you at:

Georgia Office of Insurance and Safety Fire Commissioner  
Consumer Services Division  
2 Martin Luther King, Jr. Drive  
West Tower, Suite 716  
Atlanta, GA 30334  
(800) 656-2298  
<http://www.oci.ga.gov/ConsumerService/Home.aspx>

## Section 14: Online Access to Account Information

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UnitedHealthcare **StudentResources** 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](http://www.uhcsr.com/myaccount). Insured students who don't already have an online account may simply select the "create **My Account** Now" link. Follow the simple, onscreen directions to establish an online account in minutes using the Insured's 7-digit Insurance ID number or the email address on file.

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

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

## Section 15: Important Company Contact Information

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The Policy is Underwritten by:

**UNITEDHEALTHCARE INSURANCE COMPANY**

Administrative Office:  
UnitedHealthcare **StudentResources**  
P.O. Box 809025  
Dallas, Texas 75380-9025  
Web site: [gkclaims@uhcsr.com](mailto:gkclaims@uhcsr.com)

**Customer Service:**

**1-866-948-8472**

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



## Schedule of Benefits

Savannah College of Art and Design

2019-202924-4

PLATINUM LEVEL – 88.47%

Injury and Sickness Benefits

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

<b>Deductible Preferred Provider</b>	\$50 (For each Injury or Sickness)
<b>Deductible Out-of-Network</b>	\$300 (For each Injury or Sickness)
<b>Coinsurance Preferred Provider</b>	90% to \$5,500, then 100% thereafter
<b>Coinsurance Out-of-Network</b>	70% to \$5,500, then 100% thereafter
<b>Out-of-Pocket Maximum Preferred Provider</b>	\$7,150 (Per Insured Person, Per Policy Year)
<b>Out-of-Pocket Maximum Preferred Provider</b>	\$14,300 (For all Insureds in a Family, Per Policy Year)
<b>Out-of-Pocket Maximum Out-of-Network</b>	\$14,300 (Per Insured Person, Per Policy Year)

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

The Company will pay Covered Medical Expenses incurred at 90% for Preferred Providers and 70% for Out-of-Network Providers up to \$5,500. After the Company has paid \$5,500, benefits will be paid for additional Covered Medical Expenses incurred at 100% for Preferred Providers and 100% for Out-of-Network Providers.

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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

**Out-of-Pocket Maximum:** After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network 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 will be waived for Covered Medical Expenses incurred when treatment is rendered at St. Joseph's /Candler (SJC) Medical Group.

UnitedHealthcare Pharmacy (UHCP) is the vendor the company contracts with to provide a network of pharmacies.

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

Inpatient	Preferred Provider	Out-of-Network Provider
<b>Room and Board Expense</b>	\$250 Copay per Hospital Confinement Preferred Allowance	Usual and Customary Charges
<b>Intensive Care</b>	Preferred Allowance	Usual and Customary Charges
<b>Hospital Miscellaneous Expenses</b>	Preferred Allowance	Usual and Customary Charges

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

<b>Outpatient</b>	<b>Preferred Provider</b>	<b>Out-of-Network Provider</b>
<b>Surgery</b> If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
<b>Day Surgery Miscellaneous</b>	Preferred Allowance	Usual and Customary Charges
<b>Assistant Surgeon Fees</b>	Preferred Allowance	Usual and Customary Charges
<b>Anesthetist Services</b>	Preferred Allowance	Usual and Customary Charges
<b>Physician's Visits</b>	Preferred Allowance	Usual and Customary Charges
<b>Physiotherapy</b> Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance	Usual and Customary Charges
<b>Medical Emergency Expenses</b> The Copay will be waived if admitted to the Hospital.	\$100 Copay per visit Preferred Allowance	\$100 Copay per visit 90% of Usual and Customary Charges
<b>Diagnostic X-ray Services</b>	Preferred Allowance	Usual and Customary Charges
<b>Radiation Therapy</b>	Preferred Allowance	Usual and Customary Charges
<b>Laboratory Procedures</b>	Preferred Allowance	Usual and Customary Charges
<b>Tests &amp; Procedures</b>	Preferred Allowance	Usual and Customary Charges
<b>Injections</b>	Preferred Allowance	Usual and Customary Charges
<b>Chemotherapy</b>	Preferred Allowance	Usual and Customary Charges

Other	Preferred Provider	Out-of-Network Provider
<p><b>Prescription Drugs</b></p> <p>*See UHCP Prescription Drug Benefit Endorsement for additional information.</p>	<p>*UnitedHealthcare Pharmacy (UHCP)            20% Coinsurance per prescription Tier 1,            20% Coinsurance per prescription Tier 2,            20% Coinsurance per prescription Tier 3</p> <p>up to a 31-day supply per prescription. (Note: this is the insured's portion.)</p> <p>When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Coinsurance (up to 50% of the Prescription Drug Charge).</p>	<p>20% Coinsurance per prescription (Note: this is the insured's portion.) (20% insured/80% UHCSR)</p>
<b>Ambulance Services</b>	Preferred Allowance	Usual and Customary Charges
<b>Durable Medical Equipment</b>	Preferred Allowance	Usual and Customary Charges
<b>Consultant Physician Fees</b>	Preferred Allowance	Usual and Customary Charges
<p><b>Dental Treatment</b>            Benefits paid on Injury to Sound, Natural Teeth, surgical removal of impacted teeth, or as specified in the Policy.</p>	Preferred Allowance	90% of Usual and Customary Charges
<b>Mental Illness Treatment</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Substance Use Disorder Treatment</b>	Paid as any other Sickness	Paid as any other Sickness
<p><b>Maternity</b>            See also Benefits for Postpartum Care</p>	Paid as any other Sickness	Paid as any other Sickness
<b>Complications of Pregnancy</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Elective Abortion</b>	Preferred Allowance	Usual and Customary Charges
<p><b>Preventive Care Services</b>            No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider.</p> <p>Please visit <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for a complete list of services provided for specific age and risk groups.</p>	100% of Preferred Allowance	No Benefits
<p><b>Reconstructive Breast Surgery Following Mastectomy</b>            See Benefits for Mastectomy</p>	Paid as any other Sickness	Paid as any other Sickness
<p><b>Diabetes Services</b>            See Benefits for the Management and Treatment of Diabetes</p>	Paid as any other Sickness	Paid as any other Sickness

<b>Other</b>	<b>Preferred Provider</b>	<b>Out-of-Network Provider</b>
<b>Home Health Care</b>	Preferred Allowance	Usual and Customary Charges
<b>Hospice Care</b>	Preferred Allowance	Usual and Customary Charges
<b>Inpatient Rehabilitation Facility</b>	Preferred Allowance	Usual and Customary Charges
<b>Skilled Nursing Facility</b>	Preferred Allowance	Usual and Customary Charges
<b>Urgent Care Center</b>	Preferred Allowance	Usual and Customary Charges
<b>Hospital Outpatient Facility or Clinic</b>	Preferred Allowance	Usual and Customary Charges
<b>Approved Clinical Trials</b> See also Benefits for Drugs for Treatment of Children's Cancer	Paid as any other Sickness	Paid as any other Sickness
<b>Transplantation Services</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Pediatric Dental and Vision Services</b>	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
<b>Breast Reduction Surgery</b>	Paid as any other Sickness	Paid as any other Sickness
<b>Child Wellness Services</b> No Deductible will be applied when the services are for a child age 5 and under.	Paid as any other Sickness	Paid as any other Sickness
<b>Medical Foods</b> Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
<b>Medical Supplies</b> Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
<b>Nutritional Counseling</b>	Preferred Allowance	Usual and Customary Charges
<b>Ostomy Supplies</b> Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

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



President

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

### Pediatric Dental Services Benefits

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

#### Section 1: Accessing Pediatric Dental Services

##### Network and Non-Network Benefits

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

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

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

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

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

##### Covered Dental Services

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

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

## **Pre-Treatment Estimate**

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

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

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

## **Pre-Authorization**

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

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

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

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

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

### **Network Benefits:**

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

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

### **Non-Network Benefits:**

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

### **Dental Services Deductible**

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

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

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

## Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

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

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

## Benefit Description

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<b>Diagnostic Services - (Subject to payment of the Dental Services Deductible.)</b>		
<p><i>Evaluations (Checkup Exams)</i></p> <p><i>Limited to 2 times per 12 months.</i></p> <p>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            D0150 - Comprehensive oral evaluation            D0180 - Comprehensive periodontal evaluation</p> <p><i>The following service is not subject to a frequency limit.</i></p> <p>D0160 - Detailed and extensive oral evaluation - problem focused</p>	60%	60%
<p><i>Intraoral Radiographs (X-ray)</i></p> <p><i>Limited to 2 series of films per 12 months.</i></p> <p>D0210 - Complete series (including bitewings)</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D0220 - Intraoral - periapical first film            D0230 - Intraoral - periapical - each additional film            D0240 - Intraoral - occlusal film</p>	60%	60%
<p><i>Any combination of the following services is limited to 2 series of films per 12 months.</i></p>	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings		
<i>Limited to 1 time per 36 months.</i>  D0330 - Panoramic radiograph image	60%	60%
<i>The following services are not subject to a frequency limit.</i>  D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0391 - Interpretation of diagnostic images D0470 - Diagnostic casts	60%	60%
<b>Preventive Services - (Subject to payment of the Dental Services Deductible.)</b>		
<i>Dental Prophylaxis (Cleanings)</i>  <i>The following services are limited to 2 times every 12 months.</i>  D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	60%	60%
<i>Fluoride Treatments</i>  <i>The following services are limited to 2 times every 12 months.</i>  D1206 and D1208 - Fluoride	60%	60%
<i>Sealants (Protective Coating)</i>  <i>The following services are limited to once per first or second permanent molar every 36 months.</i>  D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	60%	60%
<i>Space Maintainers (Spacers)</i>  <i>The following services are not subject to a frequency limit.</i>  D1510 - Space maintainer - fixed - unilateral D1515 - Space maintainer - fixed - bilateral D1520 - Space maintainer - removable - unilateral D1525 Space maintainer - removable bilateral D1550 - Re-cementation of space maintainer	60%	60%



Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<b>Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)</b>		
<p><i>Amalgam Restorations (Silver Fillings)</i></p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>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</p>	60%	60%
<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2330 - Resin-based composite - one surface, anterior  D2331 - Resin-based composite - two surfaces, anterior  D2332 - Resin-based composite - three surfaces, anterior  D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior</p>	60%	60%
<b>Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)</b>		
<p><i>The following services are subject to a limit of 1 time every 60 months.</i></p> <p>D2542 - Onlay - metallic - two surfaces  D2543 - Onlay - metallic - three surfaces  D2544 - Onlay - metallic - four surfaces  D2740 - Crown - porcelain/ceramic substrate  D2750 - Crown - porcelain fused to high noble metal  D2751 - Crown - porcelain fused to predominately base metal  D2752 - Crown - porcelain fused to noble metal  D2780 - Crown - 3/4 case high noble metal  D2781 - Crown - 3/4 cast predominately base metal  D2783 - Crown - 3/4 porcelain/ceramic  D2790 - Crown - full cast high noble metal</p>	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<p>D2791 - Crown - full cast predominately base metal  D2792 - Crown - full cast noble metal  D2794 Crown – titanium  D2929 – Prefabricated porcelain crown - primary  D2930 Prefabricated stainless steel crown - primary tooth  D2931 - Prefabricated stainless steel crown - permanent tooth</p> <p><i>The following services are not subject to a frequency limit.</i></p> <p>D2510 Inlay - metallic - one surface  D2520 - Inlay - metallic - two surfaces  D2530 - Inlay - metallic - three surfaces  D2910 - Re-cement inlay  D2920 - Re-cement crown</p>		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D2940 - Protective restoration</p>	60%	60%
<p><i>The following service is limited to 1 time per tooth every 60 months.</i></p> <p>D2950 - Core buildup, including any pins</p>	60%	60%
<p><i>The following service is limited to 1 time per tooth every 60 months.</i></p> <p>D2951 - Pin retention - per tooth, in addition to Crown</p>	60%	60%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D2954 - Prefabricated post and core in addition to crown</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D2980 - Crown repair necessitated by restorative material failure  D2981 – Inlay repair  D2982 – Onlay repair  D2983 – Veneer repair  D2990 – Resin infiltration/smooth surface</p>	60%	60%
<b>Endodontics - (Subject to payment of the Dental Services Deductible.)</b>		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3220 - Therapeutic pulpotomy (excluding final restoration)</p>	60%	60%

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D3230 - Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (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</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification - interim medication replacement D3353 - Apexification/recalcification - final visit</p>	60%	60%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3354 - Pulpal Regeneration</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root</p>	60%	60%
<p><i>The following service is not subject to a frequency limit.</i></p>	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D3450 - Root amputation - per root		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D3920 - Hemisection (including any root removal), not including root canal therapy</p>	60%	60%
<b>Periodontics - (Subject to payment of the Dental Services Deductible.)</b>		
<p><i>The following services are limited to a frequency of 1 every 36 months.</i></p> <p>D4210 - Gingivectomy or gingivoplasty - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three teeth D4212 - Gingivectomy or gingivoplasty – with restorative procedures – per tooth</p>	60%	60%
<p><i>The following services are limited to 1 every 36 months.</i></p> <p>D4240 - Gingival flap procedure, four or more teeth D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant</p>	60%	60%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D4249 - Clinical crown lengthening - hard tissue</p>	60%	60%
<p><i>The following services are limited to 1 every 36 months.</i></p> <p>D4260 - Osseous surgery D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant D4263 - Bone replacement graft – first site in quadrant</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D4273 - Subepithelial connective tissue graft procedures, per tooth D4275 - Soft tissue allograft</p>	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D4277 - Free soft tissue graft - first tooth D4278 - Free soft tissue graft - additional teeth		
<i>The following services are limited to 1 time per quadrant every 24 months.</i>  D4341 - Periodontal scaling and root planning - four or more teeth per quadrant D4342 - Periodontal scaling and root planning - one to three teeth per quadrant	60%	60%
<i>The following service is limited to a frequency to 1 per lifetime.</i>  D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	60%	60%
<i>The following service is limited to 4 times every 12 months in combination with prophylaxis.</i>  D4910 - Periodontal maintenance	60%	60%
<b>Removable Dentures - (Subject to payment of the Dental Services Deductible.)</b>		
<i>The following services are limited to a frequency of 1 every 60 months.</i>  D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base D5212 - Maxillary partial denture - resin base D5213 - Maxillary partial denture - cast metal framework with resin denture base D5214 - Mandibular partial denture - cast metal framework with resin denture base D5281 - Removable unilateral partial denture - one piece cast metal	60%	60%
<i>The following services are not subject to a frequency limit.</i>  D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D5422 - Adjust partial denture - mandibular D5510 - Repair broken complete denture base D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5620 - Repair cast framework D5630 - Repair or replace broken clasp D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture		
<i>The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months.</i>  D5710 - Rebase complete maxillary denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5730 - Reline complete maxillary denture D5731 - Reline complete mandibular denture D5740 - Reline maxillary partial denture D5741 - Reline mandibular partial denture D5750 - Reline complete maxillary denture (laboratory) D5751 - Reline complete mandibular denture (laboratory) D5752 - Reline complete mandibular denture (laboratory) D5760 - Reline maxillary partial denture (laboratory) D5761 - Reline mandibular partial denture (laboratory) - rebase/relines D5762 - Reline mandibular partial denture (laboratory)	60%	60%
<i>The following services are not subject to a frequency limit.</i>  D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	60%	60%
<b>Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)</b>		

<b>Benefit Description and Limitations</b>	<b>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>	<b>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</b>
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D6210 - Pontic - case high noble metal  D6211 - Pontic - case predominately base metal  D6212 - Pontic - cast noble metal  D6214 - Pontic - titanium  D6240 - Pontic - porcelain fused to high noble metal  D6241 - Pontic - porcelain fused to predominately base metal  D6242 - Pontic - porcelain fused to noble metal  D6245 - Pontic - porcelain/ceramic</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D6545 - Retainer - cast metal for resin bonded fixed prosthesis  D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D6519 - Inlay/onlay - porcelain/ceramic  D6520 - Inlay - metallic - two surfaces  D6530 - Inlay - metallic - three or more surfaces  D6543 - Onlay - metallic - three surfaces  D6544 - Onlay - metallic - four or more surfaces</p>	60%	60%
<p><i>The following services are limited to 1 time every 60 months.</i></p> <p>D6740 - Crown - porcelain/ceramic  D6750 - Crown - porcelain fused to high noble metal  D6751 - Crown - porcelain fused to predominately base metal  D6752 - Crown - porcelain fused to noble metal  D6780 - Crown - 3/4 cast high noble metal  D6781 - Crown - 3/4 cast predominately base metal  D6782 - Crown - 3/4 cast noble metal  D6783 - Crown - 3/4 porcelain/ceramic  D6790 - Crown - full cast high noble metal  D6791 - Crown - full cast predominately base metal</p>	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D6792 - Crown - full cast noble metal		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D6930 - Re-cement or re-bond fixed partial denture</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D6973 - Core build up for retainer, including any pins D6980 - Fixed partial denture repair necessitated by restorative material failure</p>	60%	60%
<b>Oral Surgery - (Subject to payment of the Dental Services Deductible.)</b>		
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7140 - Extraction, erupted tooth or exposed root</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D7210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth 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 - complete bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal</p>	60%	60%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</p>	60%	60%
<p><i>The following service is not subject to a frequency limit.</i></p> <p>D7280 - Surgical access of an unerupted tooth</p>	60%	60%
<p><i>The following services are not subject to a frequency limit.</i></p> <p>D7310 - Alveoloplasty in conjunction with extractions - per quadrant</p>	60%	60%



Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D7311 - Alveoplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant D7320 - Alveoplasty not in conjunction with extractions - per quadrant D7321 - Alveoplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant		
<i>The following service is not subject to a frequency limit.</i>  D7471 - removal of lateral exostosis (maxilla or mandible)	60%	60%
<i>The following services are not subject to a frequency limit.</i>  D7510 - Incision and drainage of abscess D7910 - Suture of recent small wounds up to 5 cm D7921 - Collect - apply autologous product D7953 - Bone replacement graft for ridge preservation - per site D7971 - Excision of pericoronal gingiva	60%	60%
<b>Adjunctive Services - (Subject to payment of the Dental Services Deductible.)</b>		
<i>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.</i>  D9110 - Palliative (Emergency) treatment of dental pain - minor procedure	60%	60%
<i>Covered only when clinically Necessary.</i>  D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9610 - Therapeutic drug injection, by report	60%	60%
<i>Covered only when clinically Necessary</i>	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)		
<i>The following is limited to 1 guard every 12 months.</i>  D9940 - Occlusal guard	60%	60%
<b>Implant Procedures - (Subject to payment of the Dental Services Deductible.)</b>		
<i>The following services are limited to 1 time every 60 months.</i>  D6010 - Endosteal implant D6012 - Surgical placement of interim implant body D6040 - Eposteal Implant D6050 - Transosteal implant, including hardware D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported D6056 - Prefabricated abutment D6057 - Custom abutment D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to high noble metal D6060 - Abutment supported porcelain fused to predominately base metal crown D6061 - Abutment supported porcelain fused to noble metal crown D6062 - Abutment supported cast high noble metal crown D6063 - Abutment supported case predominately base metal crown D6064 - Abutment supported porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported porcelain fused to high metal crown D6067 - Implant supported metal crown D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture	60%	60%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<p>D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture</p> <p>D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture</p> <p>D6072 - Abutment supported retainer for cast high noble metal fixed partial denture</p> <p>D6073 - Abutment supported retainer for predominately base metal fixed partial denture</p> <p>D6074 - Abutment supported retainer for cast metal fixed partial denture</p> <p>D6075 - Implant supported retainer for ceramic fixed partial denture</p> <p>D6076 - Implant supported retainer for porcelain fused to high noble metal fixed partial denture</p> <p>D6077 - Implant supported retainer for cast metal fixed partial denture</p> <p>D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch</p> <p>D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch</p> <p>D6080 - Implant maintenance procedure</p> <p>D6090 - Repair implant prosthesis</p> <p>D6091 - Replacement of semi-precision or precision attachment</p> <p>D6095 - Repair implant abutment</p> <p>D6100 - Implant removal</p> <p>D6101 - Debridement periimplant defect</p> <p>D6102 - Debridement and osseous periimplant defect</p> <p>D6103 - Bone graft periimplant defect</p> <p>D6104 - Bone graft implant replacement</p> <p>D6190 - Implant index</p>		
<b>Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)</b>		
<p>Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>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.</p>		

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
<p><i>The following services are not subject to a frequency limitation as long as benefits have been prior authorized.</i></p> <p>D8010 - Limited orthodontic treatment of the primary dentition  D8020 - Limited orthodontic treatment of the transitional dentition  D8030 - Limited orthodontic treatment of the adolescent dentition  D8050 - Interceptive orthodontic treatment of the primary dentition  D8060 - Interceptive orthodontic treatment of the transitional dentition  D8070 - Comprehensive orthodontic treatment of the transitional dentition  D8080 - Comprehensive orthodontic treatment of the adolescent dentition  D8210 - Removable appliance therapy  D8220 - Fixed appliance therapy  D8660 - Pre-orthodontic treatment visit  D8670 - Periodic orthodontic treatment visit  D8680 - Orthodontic retention</p>	60%	60%

### Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this endorsement in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
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, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of

replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this endorsement to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

## Section 4: Claims for Pediatric Dental Services

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

### Reimbursement for Dental Services

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

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

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

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

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

If the Insured Person would like to use a claim form, call Customer Service at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

## Section 5: Defined Terms for Pediatric Dental Services

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

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

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

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

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

**Dental Services Deductible** - the amount the Insured Person must pay for Covered Dental Services in a Policy Year before the Company will begin paying for Network or Non-Network Benefits in that Policy Year.

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

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

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

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

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

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

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

- Safe with promising efficacy
  - For treating a life threatening dental disease or condition.
  - Provided in a clinically controlled research setting.
  - Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

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

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

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

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

**Non-Network Benefits** - benefits available for Covered Dental Services obtained from Non-Network Dentists.

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

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

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

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

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

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



President

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

### Pediatric Vision Care Services Benefits

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

#### Section 1: Benefits for Pediatric Vision Care Services

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

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

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

#### Network Benefits:

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

#### Non-Network Benefits:

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

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

#### Policy Deductible

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



## Benefit Description

### Benefits

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

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

### Frequency of Service Limits

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

### Routine Vision Examination

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

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

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

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

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

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

## **Eyeglass Frames**

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

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

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

## **Contact Lenses**

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

Benefits include the fitting/evaluation fees and contacts.

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

## **Necessary Contact Lenses**

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

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

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

## Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<b>Routine Vision Examination or Refraction only in lieu of a complete exam.</b>	Once per year.	100% after a Copayment of \$20.	70% of the billed charge.
<b>Eyeglass Lenses</b>	Once per year.		
• Single Vision		100% after a Copayment of \$40.	70% of the billed charge.
• Bifocal		100% after a Copayment of \$40.	70% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	70% of the billed charge.
• Lenticular		100% after a Copayment of \$40.	70% of the billed charge.
<b>Lens Extras</b>	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<b>Eyeglass Frames</b>	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	70% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - \$160.		100% after a Copayment of \$15.	70% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - \$200.		100% after a Copayment of \$30.	70% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - \$250.		100% after a Copayment of \$50.	70% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	70% of the billed charge.
<b>Contact Lenses Fitting &amp; Evaluation</b>	Once per year.	100%	100% of the billed charge.
<b>Contact Lenses</b>			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of \$40.	70% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of \$40.	70% of the billed charge.

## Section 2: Pediatric Vision Exclusions

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

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

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

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company. Information about claim timelines and responsibilities in the General Provisions section in the Certificate of

Coverage applies to Vision Care Services provided under this endorsement, except that when the Insured Person submits a Vision Services claim, the Insured Person must provide the Company with all of the information identified below.

#### Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

1-248-733-6060

### 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 Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

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

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

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

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

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



**President**

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

### **UnitedHealthcare Pharmacy (UHCP) and Out-of-Network Pharmacy Prescription Drug Benefits**

#### **Benefits for Prescription Drug Products**

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

Benefits for Prescription Drug Products are subject to supply limits and Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. 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  $\frac{3}{4}$  of the original Prescription Drug Product has been used.

The Insured must present their ID card to the Network Pharmacy when the prescription is filled. If the Insured does not present their ID card to the Network Pharmacy, they will need to pay for the Prescription Drug and 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/scad](http://www.uhcsr.com/scad) and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

Information on Network Pharmacies is available through the Internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) or by calling *Customer Service* at 1-855-828-7716.

Benefits are available for Prescription Drugs at an Out-of-Network Pharmacy as specified in the Policy Schedule of Benefits.

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.

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

### **Supply Limits**

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.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict 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 determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) or by calling *Customer Service* at 1-855-828-7716.

### **If 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, and therefore the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular Brand-name Prescription Drug 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

through the Internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) or by calling *Customer Service* at 1-855-828-7716. If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, benefits will be provided under the Out-of-Network Prescription Drug benefit.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, benefits will be provided under the Out-of-Network Prescription Drug benefit, or, 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 determine whether a Network Pharmacy is a Preferred Specialty Network Pharmacy through the Internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) or by calling *Customer Service* at 1-855-828-7716.

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.

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, or a Designated Pharmacy.

## Notification Requirements

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 notify the Company or the Company's designee. The reason for notifying 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 Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. 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 notification through the Internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) or by calling *Customer Service* at 1-855-828-7716.

If the Company is not notified 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 notify 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.

## Limitation on 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 selection of Network Pharmacies may be limited. If this happens, the Company may require the Insured to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the designated single Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will select a single Network Pharmacy for the Insured.

## Coverage Policies and Guidelines

The Company's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on its behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

The Company may periodically change the placement of a Prescription Drug Product among the tiers. 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 status of a Prescription Drug Product may change periodically 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/scad](http://www.uhcsr.com/scad) through the Internet or call *Customer Service* at 1-855-828-7716 for the most up-to-date tier status.

## Rebates and Other Payments

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

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

## Definitions

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

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

**Designated Pharmacy** means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated 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 including, but not limited to, Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

**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 assigned to a tier by the Company's PDL Management Committee.
- December 31<sup>st</sup> of the following calendar year.

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

**Out-of-Network Pharmacy** means a pharmacy that has not been designated by the Company as a Network Pharmacy.

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

**Prescription Drug or 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 pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the Policy, this definition includes:

- Inhalers.
- Insulin.
- 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 monitors.

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

**Prescription Drug List** means a list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may

determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) or call *Customer Service* at 1-855-828-7716.

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

**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.

**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 determine whether a drug is a Preventive Care Medication through the internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) or by calling *Customer Service* at 1-855-828-7716.

**Specialty Prescription Drug Product** means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products through the Internet at [www.uhcsr.com/scad](http://www.uhcsr.com/scad) 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. The Usual and Customary 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. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven, except for cancer drugs found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in either the United States or Great Britain.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Company's PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that 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 assigned to Tier-3.)
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.
9. 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.
10. 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.
11. 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.

12. A Prescription Drug Product with an approved biosimilar or 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 showing that it is highly similar to a reference product (a biological Prescription Drug Product) and 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, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
15. Diagnostic kits and products.
16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

### **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 1-866-948-8472. The Company will notify the Insured Person of the Company's determination within 72 hours.

### **Urgent Requests**

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

### **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 1-866-948-8472. 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 1-866-948-8472 or by sending a written request to the address set out in the determination letter. The *IRO* will notify the Insured Person of the determination within 24 hours.

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

In consideration of the premium charged, this endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all the terms and conditions of the Policy not inconsistent therewith.



**President**

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

### **BENEFITS FOR TREATMENT OF MORBID OBESITY**

Benefits will be paid as any other Sickness for all medically appropriate and necessary treatment, including surgery used to treat Morbid Obesity by Health Care Providers. The diagnosis of Morbid Obesity must be a clinical decision made by a Physician based on the appropriate medical guidelines. The Insured's Physician must certify that such services are Medically Necessary.

Treatment must be in accordance with guidelines developed by the National Institute of Health, the American Society for Bariatric Surgery, the American Medical Association and the American College of Surgeons.

"Morbid Obesity" means a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Life Insurance Tables. Morbid Obesity also means a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

"Health Care Providers" means those Physicians and medical institutions that are specifically qualified to treat in a comprehensive manner the entire complex of illness and disease association with Morbid Obesity.

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

# UNITEDHEALTHCARE INSURANCE COMPANY

## POLICY ENDORSEMENT

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



President

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

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

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

### Assistance and Evacuation Benefits

#### DEFINITIONS

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

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

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

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

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

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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 access My Account at [www.uhcsr.com/MyAccount](http://www.uhcsr.com/MyAccount) and select My Benefits/Additional Benefits/UHC Global Emergency Services.

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

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

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

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

## NON-DISCRIMINATION NOTICE

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

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

Civil Rights Coordinator  
United HealthCare Civil Rights Grievance  
P.O. Box 30608  
Salt Lake City, UTAH 84130  
[UHC\\_Civil\\_Rights@uhc.com](mailto:UHC_Civil_Rights@uhc.com)

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

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

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

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

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

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

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

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



