PLEASE NOTE:
THIS DOCUMENT HAS BEEN CHANGED. SEE THE BACK COVER FOR DETAILS

**2014–2015**

# Student Injury and Sickness Insurance Plan

*Designed Especially for the Students of*

## Occidental College

UnitedHealthcare®

## Table of Contents

## Emmons Student Wellness Center

Emmons Student Wellness Center is committed to providing students at Occidental College with easily accessible, culturally sensitive, high quality medical care, short-term and crisis psychological services, advocacy support for survivors of sexual assault, and student-driven wellness and sexual assault education. Emmons staff applies a comprehensive, highly integrated approach to wellness with the goal of providing services that enhance the physical and emotional well-being of students so they may be fully engaged in all aspects of college life. Emmons aims to facilitate the development of self-care and student-initiated pursuit of health services and wellness opportunities.

### WHERE AND WHEN THE EMMONS STUDENT WELLNESS CENTER SERVICES ARE AVAILABLE

Emmons Student Wellness is located on Emmons Road, behind Coons Administrative Center.

Emmons is open Monday to Friday, 8:30 a.m. to 5:00 p.m., and may initiate being open one evening per week until 7PM. The Center is closed on holidays. Check the Emmons Student Wellness Center website for updates at www.oxy.edu/emmons-student-wellness-center.

### SERVICES PROVIDED

Emmons Student Wellness Center offers the following services to students enrolled in the plan:

- Physical Exams
- Treatment of minor illnesses and injuries
- Diagnostic services, clinical laboratory and x-ray referral
- Women's health services such as routine exams, pap smears and contraception
- Confidential HIV testing
- Referrals to medical/surgical specialists
- Immunizations
- Common prescription and over-the-counter medication at reduced cost
- Short term counseling, psychotherapy and crisis intervention to support the mental and emotional health of students, including assessment and short-term individual and small group counseling, referrals for long-term therapy, mental health services in the community and medication management, when appropriate.

Licensed nurse practitioners and/or physician assistants and psychotherapists are available every weekday. Walk-in hours and scheduled appointments are also available each weekday.

### SERVICES NOT PROVIDED

Emmons Student Wellness Center is equipped to take care of most minor, episodic physical or emotional problems. For medical services, students will be charged a $10 copayment each visit, except for preventive care services. Insurance will be billed for all medications, laboratory tests and miscellaneous items dispensed by Emmons. Dependents of enrolled students are not eligible for treatment at the Emmons Student Wellness Center.

In case of serious illness or injury requiring treatment beyond the scope of practice available at Emmons Student Wellness Center, the staff will recommend the services of a specialist, as needed. Occidental College assumes no responsibility for the expenses incurred. Thus, it is required that all students be covered by health insurance. The Occidental Student Injury and Sickness Insurance Plan is reasonable protection against the financial burden associated with those more serious accidents and illnesses.

## Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-866-948-8472 or visiting us at www.uhcsr.com.

## Eligibility

All students who are registered in a degree program are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished. All International students are automatically enrolled in this insurance Plan at registration.

Students 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 student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Brochure for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Accident coverage for Intercollegiate Sports is provided under a separate policy (2014-810-8) underwritten by UnitedHealthcare and issued to Occidental College. Contact Gallagher Student Health and Special Risk at 1-800-396-5977 for further information.

## Dependent Enrollment

Students interested in enrolling their eligible dependent(s) should go to www.gallagherstudent.com/oxy and click on 'Dependent Enroll' and complete the online form and submit it and the required premium by the deadline. Dependent coverage is in addition to the fee for your individual student coverage. The Effective Date for an Insured's eligible dependent(s) enrolled with an Insured is the Insured's Effective Date provided the required premium for the dependent(s) is received by the enrollment deadline. Dependent Enrollment Forms will not be accepted after the deadline. The deadline to add eligible dependents due to a qualifying event (i.e. birth or marriage), is 31 days from the qualifying event in order to avoid a break in continuous coverage. If the Qualifying Event deadline is not met, the effective date will be the date the online Dependent Enrollment Form is submitted.

## Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2014. The individual student'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., July 31, 2015. 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.

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

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

| Rates | Fall<br>8/1/14 - 1/19/15 | Spring<br>1/20/15 - 7/31/15 |
|---|---|---|
| Student | $863 | $863 |
| Spouse | $2,235 | $2,235 |
| All Children | $956 | $956 |
| All Dependents | $3,190 | $3,190 |

## Extension of Benefits after Termination

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

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

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

## Student Online Enroll/Waiver Process

Eligible students are automatically enrolled in and billed for the Student Injury and Sickness Insurance Plan. Students who are currently enrolled in a health insurance plan that provides comparable coverage to the Occidental College Student Injury and Sickness Insurance Plan and is in effect during the 2014-2015 academic year can request to waive the College-sponsored Student Injury and Sickness Insurance Plan.

**International students are not eligible to submit a request to waive coverage and will be enrolled in the Student Injury and Sickness Insurance Plan for the entire policy year.**
Recognizing that health insurance coverage may change, at the beginning of each academic year students will be asked to provide proof of comparable coverage to the Occidental College Student Injury and Sickness Insurance Plan in order to waive coverage.

**Enrollment / Waiver Process**
Students who want to enroll in the Student Injury & Sickness Insurance Plan are encouraged to complete an online Enrollment Form. Students who are insured through a plan of comparable coverage and want to request a waiver, need to submit a waiver form. **Students who do not complete a waiver form will by the August 1st deadline will be enrolled in the Student Injury and Sickness Insurance Plan for the entire policy year.**

To complete either an Enrollment or Waiver form:
1. Go to www.gallagherstudent/oxy
2. Click on “Student Waive /Enroll”
3. Your User Account has been created. Your User Name is your College email address and your password is your College student ID number.
4. Click on the green “I want to Enroll” button or the red “I want to Waive’ button

To complete the Online Waiver Form, have your current health insurance ID card available as you will need to provide information about your current health insurance. Upon completing your online waiver request, you will be asked to review the information and click “Continue”. Immediately upon submitting your online form you will receive a confirmation number. Print this confirmation for your records. If you do not receive a confirmation number, you will need to correct any errors and resubmit the form. **The online waiver process is the only accepted process for waiving coverage**.

Occidental College reserves the right to audit and subsequently reject a waiver or enrollment request. Your submitted waiver will be subject to a waiver verification process. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage or does not meet the eligibility guidelines the student will be automatically enrolled in the Student Injury and Sickness Insurance Plan

In the event students waives the Student Injury and Sickness Insurance Plan and then lose current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Student Health. If approved, the premium will not be prorated.

## Pre-Admission Notification

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

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

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

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

**PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHO OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.**

## Preferred Provider Information

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

UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. 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. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

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

**Inpatient Expenses**

**PREFERRED PROVIDERS** - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Options PPO 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 Options PPO will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

**MEDICAL EMERGENCY**

For the purposes of PPO coverage, medical emergency includes Active Labor. Active Labor means a labor at a time at which either of the following would occur:

1) There is inadequate time to make a safe transfer to another hospital prior to delivery.
2) A transfer may pose a threat to the health and safety of the Insured or the unborn child.

## Schedule of Medical Expense Benefits

**Platinum**
**Injury and Sickness Benefits**

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

| | |
|---|---|
| **Deductible Preferred Providers** | **$100 (Per Insured Person, Per Policy Year)** |
| **Deductible Out of Network** | **$300 (Per Insured Person, Per Policy Year)** |
| **Coinsurance Preferred Providers** | **90% except as noted below** |
| **Coinsurance Out of Network** | **70% except as noted below** |
| **Out-of-Pocket Maximum Preferred Providers** | **$6,350 (Per Insured Person, Per Policy Year)** |
| **Out-of-Pocket Maximum Preferred Providers** | **$12,700 (For all Insureds in a Family, Per Policy Year)** |

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

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

All out-of-country claims will be at 80%.

**Out-of-Pocket Maximum:** After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% up to the policy Maximum Benefit subject to any benefit maximums that may apply. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum.

**Student Wellness Center Benefits:** All covered services provided at Emmons Health Center are paid at 100% and subject to a $10 Copay per visit, except for preventive care services. Prescriptions filled at Emmons will be paid at 100% Coinsurance with no Copay.

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

| Inpatient | Preferred Provider | Out-of-Network |
|---|---|---|
| **Room and Board Expense** | Preferred Allowance | Usual and Customary Charges |
| **Intensive Care** | Preferred Allowance | Usual and Customary Charges |
| **Hospital Miscellaneous Expenses** | Preferred Allowance | Usual and Customary Charges |
| **Routine Newborn Care** | Paid as any other Sickness | Paid as any other Sickness |
| **Surgery** *(If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 100% of the second procedure and 100% of all subsequent procedures.)* | Preferred Allowance | Usual and Customary Charges |

| Inpatient | Preferred Provider | Out-of-Network |
|---|---|---|
| **Assistant Surgeon Fees** | 25% of Surgery Allowance | 25% of Surgery Allowance |
| **Anesthetist Services** | Preferred Allowance | Usual and Customary Charges |
| **Registered Nurse's Services** | Preferred Allowance | Usual and Customary Charges |
| **Physician's Visits** | Preferred Allowance | Usual and Customary Charges |
| **Pre-admission Testing**<br>(Payable within 7 working days prior to admission.) | Preferred Allowance | Usual and Customary Charges |

| Outpatient | Preferred Provider | Out-of-Network |
|---|---|---|
| **Surgery**<br>(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 100% of the second procedure and 100% of all subsequent procedures.) | Preferred Allowance | Usual and Customary Charges |
| **Day Surgery Miscellaneous**<br>Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index. | Preferred Allowance | Usual and Customary Charges |
| **Assistant Surgeon Fees** | 25% of Surgery Allowance | 25% of Surgery Allowance |
| **Anesthetist Services** | Preferred Allowance | Usual and Customary Charges |
| **Physician's Visits**<br>(Includes coverage same day as surgery.) | 100% of Preferred Allowance<br>$30 Copay per visit | Usual and Customary Charges<br>$30 Deductible per visit |
| **Physiotherapy**<br>(Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.) | Preferred Allowance | Usual and Customary Charges |
| **Medical Emergency Expenses**<br>(Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.) (The Copay/per visit Deductible will be waived if admitted to the Hospital.) | 100% of Preferred Allowance<br>$150 Copay per visit | 100% of Usual and Customary Charges<br>$150 Deductible per visit |
| **Diagnostic X-Ray Services** | Preferred Allowance | Usual and Customary Charges |
| **Radiation Therapy** | Preferred Allowance | Usual and Customary Charges |
| **Laboratory Procedures** | Preferred Allowance | Usual and Customary Charges |
| **Tests & Procedures** | Preferred Allowance | Usual and Customary Charges |
| **Injections** | Preferred Allowance | Usual and Customary Charges |
| **Chemotherapy** | Preferred Allowance | Usual and Customary Charges |
| **Prescription Drugs** | UnitedHealthcare Pharmacy (UHCP)<br>$15 Copay per prescription for Tier 1<br>$30 Copay per prescription for Tier 2<br>$50 Copay per prescription for Tier 3<br>up to a 31 day supply per prescription<br>(Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply.)<br>(Benefits also covered at Emmons Student Wellness Center 100% with no Copay.) | No Benefits |

| Other | Preferred Provider | Out-of-Network |
|---|---|---|
| **Ambulance Services** | Preferred Allowance | Usual and Customary Charges |
| **Durable Medical Equipment** (See also Benefits for Prosthetic Devices for Speaking Post Laryngectomy) | Preferred Allowance | Usual and Customary Charges |
| **Consultant Physician Fees** | Preferred Allowance | Usual and Customary Charges |
| **Dental Treatment** (Benefits paid on Injury to Natural Teeth only.) | 100% of Usual and Customary Charges | 100% of Usual and Customary Charges |
| **Mental Illness Treatment** (See also Benefits for Severe Mental Illnesses and Serious Emotional Disturbances) (Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.) | Paid as any other Sickness | Paid as any other Sickness |
| **Substance Use Disorder Treatment** (Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.) | Paid as any other Sickness | Paid as any other Sickness |
| **Maternity** | Paid as any other Sickness | Paid as any other Sickness |
| **Elective Abortion** | Paid as any other Sickness | Paid as any other Sickness |
| **Complications of Pregnancy** | Paid as any other Sickness | Paid as any other Sickness |
| **Preventive Care Services** No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. | 100% of Preferred Allowance | No Benefits |
| **Reconstructive Breast Surgery Following Mastectomy** | Paid as any other Sickness | Paid as any other Sickness |
| **Diabetes Services** (See Benefits for Diabetes) | Paid as any other Sickness | Paid as any other Sickness |
| **Home Health Care** | Preferred Allowance | Usual and Customary Charges |
| **Hospice Care** | Preferred Allowance | Usual and Customary Charges |
| **Skilled Nursing Facility** | Preferred Allowance | Usual and Customary Charges |
| **Urgent Care Center** | Preferred Allowance | Usual and Customary Charges |
| **Hospital Outpatient Facility or Clinic** | Preferred Allowance | Usual and Customary Charges |
| **Approved Clinical Trials** (See also Benefits for Cancer Clinical Trials) | Paid as any other Sickness | Paid as any other Sickness |
| **Transplantation Services** | Paid as any other Sickness | Paid as any other Sickness |
| **Medical Foods** (See also Benefits for Phenylketonuria) | Preferred Allowance | Usual and Customary Charges |
| **Ostomy and Urological Supplies** | Preferred Allowance | Usual and Customary Charges |
| **Vision Correction** | Preferred Allowance | Usual and Customary Charges |

## UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the

PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

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

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

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

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

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

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

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

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

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

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)
7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. 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.
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.

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

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

Exceptions:

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

**Unproven Services** means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

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

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

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, in its discretion, 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.

**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, 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 our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

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

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

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

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

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

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

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

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

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

## Medical Expense Benefits – Injury and Sickness

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

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

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

## Inpatient

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

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

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

4. **Routine Newborn Care.**
   While Hospital Confined and routine nursery care provided immediately after birth.
   Benefits will be paid for an inpatient stay of at least:
   - 48 hours following a vaginal delivery.
   - 96 hours following a cesarean section delivery.

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

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

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

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

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

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

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

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

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

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

## Outpatient

11. **Surgery (Outpatient).**
    Physician's fees for outpatient surgery.

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

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

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

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

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

16. **Physiotherapy (Outpatient).**
    Includes but is not limited to the following rehabilitative services (including Habilitative Services):
    - Physical therapy.
    - Occupational therapy.
    - Cardiac rehabilitation therapy.
    - Manipulative treatment, unless excluded in the policy.
    - 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 (Outpatient).**
    Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.

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

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

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

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

21. **Tests and Procedures (Outpatient).**

Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:

- Physician's Visits.
- Physiotherapy.
- X-Rays.
- Laboratory Procedures.

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

- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.

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

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

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

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

## Other

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

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

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

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

    See also Benefits for Prosthetic Devices for Speaking Post Laryngectomy.

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 Natural Teeth.

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

Benefits will also be paid the same as any other Sickness for:

- Dental services to prepare the Insured's jaw for radiation therapy of cancer in the head or neck. Benefits include dental evaluations, x-rays, fluoride treatment and extractions when services are provided by a Physician or by a Dentist, when referred by a Physician.
- Facility and general anesthesia charges associated with a dental procedure which would not ordinarily require general anesthesia when the Insured:
  1) Is under age 7.
  2) Is developmentally disabled or whose health is compromised.
  3) Has an underlying medical condition which requires that the dental procedure be provided in a Hospital or outpatient surgery center.
- Dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services which are an integral part of a covered reconstructive surgery for cleft palate.

Pediatric dental benefits are provided in the Pediatric Dental Services endorsement attached.

29. **Mental Illness Treatment.**

Benefits will be paid for services received:

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

See also Benefits for Severe Mental Illnesses and Serious Emotional Disturbances.

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.

31. **Maternity.**

Same as any other Sickness.

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

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

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

32. **Complications of Pregnancy.**

Same as any other Sickness.

33. **Preventive Care Services.**

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

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

- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

34. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy.
Benefits include:
- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of mastectomy, including lymphedemas.

35. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes. See Benefits for 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.
- Incontinence supplies, including disposable incontinence under pads and adult incontinence garments.

38. **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.

39. **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.

40. **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.

41. **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 Cancer Clinical Trials.

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

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

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

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

43. **Medical Foods**:
Benefits are payable for elemental dietary enteral formulas for the primary therapy for regional enteritis (Chron's Disease). Medical foods must be prescribed by a Physician. The written prescription must accompany the claim when submitted.

See also Benefits for Phenylketonuria.

44. **Ostomy and Urological Supplies.**
Benefits are limited to the following supplies:

- Ostomy Supplies, including: adhesives and adhesive remover, ostomy belt, hernia belt, catheter, skin wash/cleaner, bedside drainage bag and bottle, urinary leg bags, gauze pads, irrigation faceplate, irrigation sleeve, irrigation bag, irrigation cone/catheter, lubricant, urinary connectors, gas filters, ostoy deodorants, drain tube attachment devices, gloves, stoma caps, colostomy plug, ostomy inserts, urinary and ostomy pouches, barriers, pouch closures, ostomy rings, ostomy face plates, skin barrier, skin sealant and tape (waterproof and non-waterproof).
- Urological Supplies, including: adhesive catheter skin attachment, catheter insertion trays with and without catheter and bag, male and female external collecting devices, male external catheter with integral collection chamber, irrigation tubing sets, indwelling catheters, foley catheters, intermittent catheters, cleaners, skin sealants, bedside and leg drainage bags, bedside bad drainage bottle, catheter leg straps, irrigation tray, irrigation syringe, lubricating gel, sterile individual packets, tubing and connectors, catheter clamp or plug, penile clamp, urethral clamp or compression device, tape (waterproof and non-waterproof), and catheter anchoring device.

Benefits are not available for ostomy and urological supplies that are comfort, convenience, or luxury equipment or features or for other items that are not listed above.

45. **Vision Correction**.
    Benefits are payable only for the following:
    - Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) per Policy Year to treat aniridia.
    - Up to six Medically Necessary contact lenses per eye (including fitting and dispensing) per Policy Year to treat aphakia for Insureds through age 9.

## Maternity Testing

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

**Initial screening at first visit:**

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

**Each visit:** Urine analysis

**Once every trimester:** Hematocrit and Hemoglobin

**Once during first trimester:** Ultrasound

**Once during second trimester:**

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

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

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

**Once during third trimester:** Group B Strep Culture

Pre-natal vitamins are not covered, except folic acid supplements with a written prescription. For additional information regarding Maternity Testing, please call the Company at 1-866-948-8472.

## BENEFITS FOR TELEHEALTH SERVICES

Benefits for appropriately provided Telehealth services will be paid on the same basis as services provided through a face-to-face contact between a Physician and Insured.

"Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care Provider at a distant site without the presence of the patient.

"Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-managements of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

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

## BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Covered Medical Expense as shown in the Schedule of Benefits for screening by low-dose mammography for the presence of occult breast cancer, upon the referral of a nurse practitioner, certified nurse midwife, or Physician, subject to the following guidelines:

1) A baseline mammogram for women thirty-five to thirty-nine years of age, inclusive.
2) A mammogram every two years for women forty to forty-nine years of age or more frequently based on the woman's Physician's recommendation.
3) An annual mammogram for women fifty years of age or older.

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

## BENEFITS FOR UPPER OR LOWER JAWBONE SURGERY

Benefits will be paid the same as any other Injury or Sickness for surgical procedures for those covered conditions directly affecting the upper or lower jawbone, or associated bone joints provided the service is considered a Medical Necessity and does not include dental procedures other than those identified in the Schedule of Benefits.

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

## BENEFITS FOR RECONSTRUCTIVE SURGERY

Benefits will be paid the same as any other Injury or Sickness for reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (2) to create a normal appearance, to the extent possible.

This benefit does not include cosmetic surgery or surgery performed to alter or reshape normal structures of the body in order to improve the Insured's appearance.

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

## BENEFITS FOR PROSTHETIC DEVICES FOR SPEAKING POST LARYNGECTOMY

Benefits will be paid the same as any other prosthetic device for Prosthetic Devices to restore a method of speaking incident to a laryngectomy.

For the purposes of this section "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to an order of the Insured's Physician and surgeon. "Prosthetic devices" does not include electronic voice producing machines.

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

## BENEFITS FOR SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTRUBRANCES

Benefits will be paid the same as any other Sickness for the diagnosis and Medically Necessary treatment of Severe Mental Illnesses of an Insured of any age and of Serious Emotional Disturbances of an Insured child as specified below:

1) Outpatient services.
2) Inpatient hospitalization services.
3) Partial hospitalization services.
4) Prescription Drugs.

"Severe Mental Illness" includes:

1) Schizophrenia.
2) Schizoaffective disorder.
3) Bipolar disorder (manic-depressive disorder)
4) Major depressive disorders.
5) Panic disorder.
6) Obsessive-Compulsive disorder.
7) Pervasive developmental disorder or Autism.
8) Anorexia nervosa.
9) Bulimia nervosa.

"Serious emotional disturbance of a child" means a child under the age of 18 years who has one or more mental disorders as identified in the most recent edition of the ***Diagnostic and Statistical Manual of Mental Disorders***, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population must meet one or more of the following criteria:

1) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: (i) the child is at risk of removal from home or has already been removed from the home. (ii) The mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment.
2) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
3) The child meets special education eligibility requirements under Chapter 26.5 of division 7 of Title 1 of the Government Code.

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

## BENEFITS FOR BEHAVIORAL HEALTH TREATMENT FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

Benefits will be paid the same as any other Sickness for the diagnosis and Medically Necessary Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.

"Behavioral Health Treatment" means professional services and treatment programs, including applied behavioral analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism, and that meet all the following:

1) The treatment is prescribed by a licensed Physician or Psychologist.
2) The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider that is administered by:
   a. A Qualified Autism Service Provider.
   b. A Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider.
   c. A Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider.

3) The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific Insured Person being treated. The treatment plan shall be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate. In the plan, the Qualified Autism Service Provider shall:
   a. Describe the Insured Person's behavioral health impairments to be treated.
   b. Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goals and objectives, and the frequency at which the Insured Person's progress is evaluated and reported.
   c. Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism.
   d. Discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
4) The treatment plan is not used for the purposes of provided or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the Company upon request.

"Qualified autism service provider" means either of the following:

1) A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
2) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 of the Business and Professions Code, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the licensee.

"Qualified autism service professional" means an individual who meets all of the following criteria:

1) Provides behavioral health treatment.
2) Is employed and supervised by a Qualified Autism Service Provider.
3) Provides treatment pursuant to ta treatment plan developed and approved by the Qualified Autism Service Provider.
4) Is a behavioral service provider approved as a vendor by a California regional center to provide services as a Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.
5) Has training and experience in providing services for Pervasive Developmental Disorder or Autism pursuant to Division 4.5 of the Welfare and Institutions Code or Title 14 of the Government Code.

"Qualified autism service paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:

1) Is employed and supervised by a Qualified Autism Service Provider.
2) Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
3) Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.
4) Has adequate education, training, and experience, as certified by a Qualified Autism Services Provider.

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

## BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the management and treatment of insulin using diabetes, non-insulin using diabetes, and gestational diabetes as Medically Necessary even if the items are available without a prescription:

1) Blood glucose monitors and blood glucose testing strips.
2) Blood glucose monitors designed to assist the visually impaired.
3) Insulin pumps and all related necessary supplies.
4) Ketone urine testing strips.
5) Lancets and lancet puncture devices.
6) Pen delivery systems for the administration of insulin.
7) Podiatric devices to prevent or treat diabetes-related complications.
8) Insulin syringes.
9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Benefits will also be provided for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable the Insured to properly use the equipment, supplies and medications noted above. The same policy limits will apply as apply to any other Physician's Visits.

Benefits will be paid the same as any other Prescription Drug for the following Medically Necessary prescription:

1) Insulin.
2) Prescriptive medications for the treatment of diabetes.
3) Glucagon.

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

## BENEFITS FOR PHENYLKETONURIA

Benefits will be paid for the Usual and Customary Charges for the testing and treatment of Phenylketonuria (PKU).

Benefits include those Formulas and Special Food Products that are part of a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Benefits are not required except to the extent that the cost of necessary Formulas and Special Food Products exceeds the cost of a normal diet.

"Formula" means an enteral product for use at home prescribed by a Physician or nurse practitioner or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments as Medically Necessary for the treatment of PKU.

"Special food product" means a food product that is both:
1) Prescribed by a Physician or nurse practitioner for the treatment of PKU and is consistent with the recommendations and best practices of qualified health professional with expertise germane to, and experienced in the treatment and care of, PKU. It does not include a food that is naturally low in protein, but may include a food product that is specifically formulated to have less than one gram of protein per serving.
2) Used in place of normal food products, such as grocery store foods, used by the general population.

The Deductible, Copayment and Coinsurance provisions of the Policy shall not apply; however, all other policy limitations and provisions will apply.

## BENEFITS FOR OSTEOPOROSIS

Benefits will be paid for the Usual and Customary Charges for the diagnosis, treatment and appropriate management of Osteoporosis. Benefits include all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

The Deductible, Copayment and Coinsurance provisions of the Policy shall not apply; however, all other policy limitations and provisions will apply.

## BENEFITS FOR CANCER CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for all routine patient care costs related to the clinical trial for an insured diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer.

"Routine patient care costs" means the costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered under the plan or contract if those drugs, items, devices and services were not provided in connection with an approved clinical trial program.

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

## BENEFITS FOR BREAST CANCER SCREENING AND TREATMENT

Benefits will be paid the same as any other Sickness for the screening for, diagnosis of, and treatment for breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's participating physician.

Treatment for breast cancer shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy.

"Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed Physician and surgeon.

"Prosthetic device" means the provision of initial and subsequent devices as ordered by an Insured Person's Physician and surgeon.

Benefits for prosthetic devices and reconstructive surgery shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

## BENEFITS FOR AIDS VACCINE

Benefits will be paid for the Usual and Customary Charges for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the federal Food and Drug Administration (excluding an investigational new drug application) and that is recommended by the United States Public Health Service.

The Deductible, Copayment and Coinsurance provisions of the Policy shall not apply; however, all other policy limitations and provisions will apply.

## BENEFITS FOR HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTS

Benefits will be paid the same as any other Sickness for Human Immunodeficiency Virus (HIV) testing, regardless of whether the test is related to a primary HIV diagnosis. The testing method shall be that which is approved by the federal Food and Drug Administration and is recommended by the United States Public Health Service.

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

## BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for screening and diagnosis of prostate cancer, including, but not limited to prostate-specific antigen testing (PSA) and digital rectal examinations when medically necessary and consistent with good professional practice.

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

### BENEFITS FOR CANCER SCREENING TESTS

Benefits will be paid the same as any other Sickness for all generally medically accepted cancer screening tests.

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

### BENEFITS FOR CERVICAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for an annual cervical cancer screening test, upon the referral of a nurse practitioner, certified nurse midwife, or Physician.

An annual screening test will include:

1) The conventional Pap test.
2) A human papilloma virus screening test that is approved by the federal Food and Drug Administration.
3) The option of any cervical cancer screening test approved by the federal Food and Drug Administration, upon referral by the Insured's health care provider.

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

### BENEFITS FOR OUTPATIENT CONTRACEPTIVE DRUGS AND METHODS

Benefits will be paid the same as any other Sickness for prescribed contraceptive drugs and methods which are:

1) Approved by the Federal Food and Drug Administration.
2) Prescribed by the Insured's Physician.
3) Medically appropriate for the Insured

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

## Accidental Death and Dismemberment Benefits

**Loss of Life, Limb or Sight**

If such Injury shall independently of all other causes and within 180 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 | $1,500 |
| Two or More Members | $1,500 |
| One Member | $750 |
| Thumb or Index Finger | $500 |

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

## Definitions

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

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

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

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

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

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

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

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

**DOMESTIC PARTNER** means a person who has filed a Declaration of Domestic Partnership with the California Secretary of State and who meets all of the following:

1) Is unmarried or is not a member of another domestic partnership.
2) Is not related by blood to the Insured Person in a way that would prevent marriage in this state.
3) Is at least 18 years of age; or, if under age 18, has, in accordance with California Law, obtained:
   a. Written consent from the underage person's parents and a court order granting permission to establish a domestic partnership; or
   b. A court order establishing a domestic partnership if the underage person does not have a parent or legal guardian or a parent of legal guardian capable of consenting to the domestic partnership.
4) Is mentally capable of consenting to the domestic partnership.

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

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

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 Medically Necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skill and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or educational services of any kind, including but not limited to vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

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

**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 this 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 this policy's Effective Date will be considered a Sickness under this policy.

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

**INSURED PERSON** means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium 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.

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

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

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

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

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

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

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

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

**NATURAL TEETH** means natural teeth, where the major portion of the individual tooth is present, regardless of fillings or caps.

**NEWBORN INFANT** means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. 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 us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

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

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

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

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

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

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

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

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

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

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

## Exclusions and Limitations

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

1. Behavioral problems. Conceptual handicap. Developmental delay or disorder or mental retardation. Learning disabilities. Milieu therapy. Parent-child problems.
2. Circumcision.
3. Congenital Conditions, except as specifically provided for:
   - Habilitative Services.
   - Benefits for Reconstructive Surgery.
   - Cleft palate as described under Dental Treatment in the policy.
   - Newborn or adopted Infants.
4. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.
5. Dental treatment, except:
   - For accidental Injury to Natural Teeth.
   - As described under Dental Treatment in the policy.

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

   This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
9. 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.
   - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
10. Hirsutism. Alopecia.
11. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
13. Injury sustained while:
   - Participating in any interscholastic, intercollegiate, or professional sport, contest or competition.
   - Traveling to or from such sport, contest or competition as a participant.
   - Participating in any practice or conditioning program for such sport, contest or competition.
14. Lipectomy.
15. Voluntary participation in a riot or civil disorder. Commission of or attempt to commit a felony.
16. Prescription Drug Services – no benefits will be payable for:
   - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
   - Immunization agents, except as specifically provided in the policy. Biological sera.
   - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
   - Products used for cosmetic purposes.
   - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
   - Anorectics - drugs used for the purpose of weight control.

- Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
- Growth hormones, except when used for the long-term treatment of Insureds under age 19 with growth failure from the lack of adequate endogenous growth hormone secretion.
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

17. Reproductive/Infertility services including but not limited to the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing, except for the prenatal diagnosis of fetal genetic disorders.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Fertility tests.
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Female sterilization procedures, except as specifically provided in the policy.
    - Reversal of sterilization procedures.
    - Sexual reassignment surgery.
18. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To benefits specifically provided in the policy.
    - To eye examinations, including preventive screenings, for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.
19. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
20. Preventive care services, except as specifically provided in the policy, including:
    - Routine physical examinations and routine testing.
    - Preventive testing or treatment.
    - Screening exams or testing in the absence of Injury or Sickness.
21. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
22. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
23. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
24. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
25. Supplies, except as specifically provided in the policy.
26. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
27. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
28. 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).
29. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat.

## FrontierMEDEX: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you and your insured spouse, Domestic Partner and minor child(ren) are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

International Students, insured spouse, Domestic Partner and insured minor child(ren): You are eligible to receive FrontierMEDEX services worldwide, except in your home country.

Domestic Students, insured spouse, Domestic Partner and insured minor child(ren): You are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment. If the condition is an emergency, You should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. We will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine and Blood Transfers
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance Payments (when included with Your enrollment in a UnitedHealthcare **Student**Resources health insurance policy)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services

Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:
1-800-527-0218 Toll-free within the United States
1-410-453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX Operations Center, please be prepared to provide:

1) Caller's name, telephone and (if possible) fax number, and relationship to the patient;
   Patient's name, age, sex, and FrontierMEDEX ID Number as listed on your Medical ID Card;
   Description of the patient's condition;
   Name, location, and telephone number of hospital, if applicable;
   Name and telephone number of the attending physician; and
   Information of where the physician can be immediately reached.

FrontierMEDEX is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in ***My Account*** at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

## Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

## Online Access to Account Information

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

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

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

## UnitedHealth Allies

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

## Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

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

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

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

Submit the above information to the Company by mail:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025
1-866-948-8462
GKclaims@uhcsr.com

## Pediatric Dental Services Benefits

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

**Section 1: Accessing Pediatric Dental Services**

**Network and Non-Network Benefits**

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

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

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

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

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

**Covered Dental Services**

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

**Pre-Treatment Estimate**

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

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

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

**Pre-Authorization**
Pre-authorization is required for all 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.

If a treatment plan is not submitted, the Insured Person will be responsible for payment of any dental treatment not approved by the Company. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a Benefit based on the less costly procedure.

## Section 2: Benefits for Pediatric Dental Services

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

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

**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.

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

| Benefit Description 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. |
|---|---|---|
| *Diagnostic Services* | | |
| *Intraoral Bitewing Radiographs (Bitewing X-ray)* Limited to 1 set of films every 6 months. | 50 % | 50 % |
| *Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays)* Limited to 1 film every 60 months. | 50 % | 50 % |
| *Periodic Oral Evaluation (Check up Exam)* Limited to 1 every 6 months. Covered as a separate Benefit only if no other service was done during the visit other than X-rays. | 50 % | 50 % |
| *Preventive Services* | | |
| *Dental Prophylaxis (Cleanings)* Limited to 1 every 6 months. | 50 % | 50 % |
| *Fluoride Treatments* Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis. | 50 % | 50 % |
| *Sealants (Protective Coating)* Limited to one sealant per tooth | 50 % | 50 % |

| 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. |
|---|---|---|
| every 36 months. | | |
| ***Space Maintainers*** | | |
| *Space Maintainers*<br>Limited to one per 60 months. Benefit includes all adjustments within 6 months of installation. | 50 % | 50 % |
| ***Minor Restorative Services, Endodontics, Periodontics and Oral Surgery*** | | |
| *Amalgam Restorations (Silver Fillings)*<br>Multiple restorations on one surface will be treated as a single filling. | 50 % | 50 % |
| *Composite Resin Restorations (Tooth Colored Fillings)*<br>For anterior (front) teeth only. | 50 % | 50 % |
| *Periodontal Surgery (Gum Surgery)*<br>Limited to one quadrant or site per 36 months per surgical area. | 50 % | 50 % |
| *Scaling and Root Planing (Deep Cleanings)*<br>Limited to once per quadrant per 24 months. | 50 % | 50 % |
| *Periodontal Maintenance (Gum Maintenance)*<br>Limited to 4 times per 12 month period following active and adjunctive periodontal therapy, within the prior 24 months, exclusive of gross debridement. | 50 % | 50 % |
| *Endodontics (root canal therapy) performed on anterior teeth, bicuspids, and molars*<br><br>*Limited to once per tooth per lifetime.*<br>*Endodontic Surgery* | 50 % | 50 % |
| *Simple Extractions (Simple tooth removal)*<br>Limited to 1 time per tooth per lifetime. | 50 % | 50 % |
| *Oral Surgery, including Surgical Extraction* | 50 % | 50 % |
| ***Adjunctive Services*** | | |
| *General Services (including Emergency Treatment of dental pain)*<br>Covered as a separate Benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. | 50 % | 50 % |

| 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. |
|---|---|---|
| Occlusal guards for Insureds age 13 and older<br>Limited to one guard every 12 months. | 50 % | 50 % |
| *Major Restorative Services* | | |
| *Inlays/Onlays/Crowns (Partial to Full Crowns)*<br>Limited to once per tooth per 60 months. Covered only when silver fillings cannot restore the tooth. | 50 % | 50 % |
| *Fixed Prosthetics (Bridges)*<br>Limited to once per tooth per 60 months. Covered only when a filling cannot restore the tooth. | 50 % | 50 % |
| *Removable Prosthetics (Full or partial dentures)*<br>Limited to one per consecutive 60 months. No additional allowances for precision or semi-precision attachments. | 50 % | 50 % |
| *Relining and Rebasing Dentures*<br>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to once per 36 months. | 50 % | 50 % |
| *Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns*<br>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per 24 months. | 50 % | 50 % |
| *Implants* | | |
| *Implant Placement*<br>Limited to once per 60 months. | 50 % | 50 % |
| *Implant Supported Prosthetics*<br>Limited to once per 60 months. | 50 % | 50 % |
| *Implant Maintenance Procedures*<br>Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to once per 60 months. | 50 % | 50 % |
| *Repair Implant Supported Prosthesis by Report*<br>Limited to once per 60 months. | 50 % | 50 % |
| *Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium*<br>Limited to once per 60 months. | 50 % | 50 % |
| *Repair Implant Abutment by Support*<br>Limited to once per 60 months. | 50 % | 50 % |

| 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. |
|---|---|---|
| *Radiographic/Surgical Implant Index by Report*<br>Limited to once per 60 months. | 50 % | 50 % |
| *MEDICALLY NECESSARY ORTHODONTICS* | | |
| Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.<br>All orthodontic treatment must be prior authorized. | | |
| *Orthodontic Services*<br>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. | 50% | 50% |

**Section 3: Pediatric Dental Exclusions**

The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy. Except as may be specifically provided under Section 2: Benefits for Covered Dental Services, benefits are not provided for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. 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 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's Effective Date of coverage.
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. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
21. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
22. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
23. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

## Section 4: Claims for Pediatric Dental Services

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

### Reimbursement for Dental Services

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

### Claim Forms

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

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

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

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

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

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

**Section 5: Defined Terms for Pediatric Dental Services**
The following definitions are in addition to the policy DEFINITIONS:

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

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

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

**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.

## Pediatric Vision Care Services Benefits

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

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

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

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

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

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

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

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

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

**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 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 following Optional Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

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

**Contact Lenses** - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

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

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

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

**Schedule of Benefits**

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

| | | | |
|---|---|---|---|
| • *Lenticular* | | 100% after a Copayment of $40. | 50% of the billed charge. |
| *Eyeglass Frames* | Once per year. | | |
| • *Eyeglass frames with a retail cost up to $130.* | | 100% | 50% of the billed charge. |
| • *Eyeglass frames with a retail cost of $130 - $160.* | | 100% after a Copayment of $15. | 50% of the billed charge. |
| • *Eyeglass frames with a retail cost of $160 - $200.* | | 100% after a Copayment of $30. | 50% of the billed charge. |
| • *Eyeglass frames with a retail cost of $200 - $250.* | | 100% after a Copayment of $50. | 50% of the billed charge. |
| • *Eyeglass frames with a retail cost greater than $250.* | | 60% | 50% of the billed charge. |
| *Contact Lenses* | Limited to a 12 month supply. | | |
| • *Covered Contact Lens Selection* | | 100% after a Copayment of $40. | 50% of the billed charge. |
| • *Necessary Contact Lenses* | | 100% after a Copayment of $40. | 50% of the billed charge. |

**Section 2: Pediatric Vision Exclusions**
The following Exclusions are in addition to those listed in the EXCLUSIONS AND LIMITATIONS of the policy.

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

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

**Section 3: Claims for Pediatric Vision Care Services**
When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

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

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

Submit the above information to the Company:

By mail:
Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
By facsimile (fax):
1-248-733-6060

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.

**Section 4: Defined Terms for Pediatric Vision Care Services**
The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

## Notice of Appeal Rights

**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 StudentResources, PO Box 809025, Dallas, TX 75380-9025.

**Expedited Internal Appeal**
For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Appeal.

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.

**Right to External Independent Medical Review**

An Insured Person may apply to the Department of Insurance for an External Independent Medical Review when the Insured Person receives a Final Adverse Benefit Determination which denies, modifies, or delays health care services based, in whole or in part, on a finding that the disputed health care services are not Medically Necessary or are not Covered Medical Expenses under the Policy. The Insured's request for an External Independent Medical Review must be submitted to the Department within six months after the Insured receives the Final Adverse Benefit Determination notice. However, the Commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

As part of its notification to the Insured regarding a disposition of the Insured's Final Adverse Benefit Determination, the Company shall provide an application form approved by the Department, and an addressed envelope, which the Insured may return to initiate an External Independent Medical Review.

**Where to Send Requests for External Independent Medical Review**

All requests for External Independent Medical Review shall be submitted to the state insurance department at the following address:

California Department of Insurance
Health Claims Bureau, IMR Unit
300 S. Spring Street
11th Floor
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641

**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 Independent Medical Review.

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

Department of Managed Health Care Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
Toll-Free: 1-888-466-2219
Fax: 1-916-255-5241
Website: www.healthhelp.ca.gov
Email: helpline@dmhc.ca.gov

The Plan is Underwritten by:
UnitedHealthcare Insurance Company

Administrative Office:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-866-948-8472
1-469-229-6700
gkclaims@uhcsr.com

QUESTIONS? NEED MORE INFORMATION?
For general information on benefits, eligibility and enrollment, ID Cards, please contact:
Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
1-800-396-5977
Email: oxystudent@gallagherstudent.com
www.gallagherstudent.com/oxy

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

This Brochure is based on Policy # 2014-810-2.

V17 NOC 2

UnitedHealthcare
A UnitedHealth Group Company

**POLICY NUMBER: 2014-810-2**

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

**NOC#2 8/27/14**
Pediatric Vision phone number updated to 1-800-839-3242.