UNITEDHEALTHCARE INSURANCE COMPANY
STUDENT INJURY AND SICKNESS INSURANCE PLAN
CERTIFICATE OF COVERAGE
THIS CERTIFICATE CONTAINS A DEDUCTIBLE PROVISION
Designed Especially for the Domestic Students of

The University of Tampa
2017-2018

EXCESS INSURANCE

The Plan is underwritten by
UNITEDHEALTHCARE INSURANCE COMPANY

TOLL-FREE NUMBER FOR INQUIRIES: For inquiries and to obtain information about your coverage, or for assistance in resolving a complaint, please call (800) 767-0700.

This Certificate of Coverage is Part of Policy # 2017-629-1

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

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

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON’S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.
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COL-17-FL CERT
Introduction

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

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

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

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

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

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

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

Section 1: Who Is Covered

The Master Policy covers students and their eligible Dependents who have met the Policy’s eligibility requirements (as shown below) and who:

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

All registered Domestic undergraduate students taking 12 or more credit hours are required to purchase this insurance plan on a mandatory basis. Domestic graduate students are eligible to enroll in this insurance plan on a voluntary basis.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student’s legal spouse and dependent children under 26 years of age. The Named Insured may also cover a Dependent child to the end of the year in which the Dependent reaches age 30 under certain circumstances.

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

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

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

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2017. The Insured Person’s coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., July 31, 2018. The Insured Person’s coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

If paying premiums by session, coverage expires as follows:

<table>
<thead>
<tr>
<th>Term</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td>8-1-17</td>
<td>12-31-17</td>
</tr>
<tr>
<td>Spring/Summer</td>
<td>1-1-18</td>
<td>7-31-18</td>
</tr>
</tbody>
</table>

The Insured Person must meet the eligibility requirements each time a premium payment is made. To avoid a lapse in coverage, the Insured Person’s premium must be received within 14 days after the coverage expiration date. It is the Insured Person’s responsibility to make timely premium payments to avoid a lapse in coverage.

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

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

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date.

If an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the Termination Date.

If an Insured is pregnant on the Termination Date and the conception occurred while covered under this Policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.

If an Insured is receiving dental treatment on the Termination Date for a covered dental procedure, Covered Medical Expenses for such dental procedures will continue to be paid subject to all of the following:

1. The course of treatment or dental procedure was recommended in writing and commenced, in connection with a specific Injury or Sickness incurred while the Policy was in effect, by the attending Physician or dentist to the Insured while the Insured was covered by the Policy.

2. The dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services.

3. The dental procedures were performed within 90 days after the Insured’s coverage ceased under the Policy and the termination of coverage did not occur as a result of the Insured’s, or in the case of a Dependent child, the child’s parents voluntary termination of coverage.

4. The extension of benefits for dental procedures terminates upon the earlier of:
   - The end of the 90-day period specified in 3 above.
   - The date the Insured becomes covered under a succeeding policy providing coverage or services for similar dental procedures. If coverage or services for the dental procedures are excluded by the succeeding policy through the use of an elimination period, the Insured is not covered by the succeeding policy and the extension of benefits does not terminate.
The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

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

Section 4: Pre-Admission Notification

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

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

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

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

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

Section 5: Preferred Provider Information

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

UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. A list of Preferred Providers is located on the plan’s web site at www.uhcsr.com. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-224-4846 and/or by asking the provider when making an appointment for services.

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

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

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

**Inpatient Expenses**

**Preferred Providers** – Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call (888) 224-4846 for information about Preferred Hospitals.

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

**Outpatient Hospital Expenses**

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.
Professional & Other Expenses
Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Section 6: Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

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

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

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

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

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

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

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

7. **Anesthetist Services.**
   Professional services administered in connection with Inpatient surgery.
8. **Registered Nurse's Services.**

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

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

9. **Physician's Visits.**

Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:
- Complete blood count.
- Urinalysis.
- Chest X-rays.

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

**Outpatient**

11. **Surgery.**

Physician's fees for outpatient surgery.

12. **Day Surgery Miscellaneous.**

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

13. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with outpatient surgery.

14. **Anesthetist Services.**

Professional services administered in connection with outpatient surgery.

15. **Physician's Visits.**

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

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

16. **Physiotherapy.**

Includes but is not limited to the following rehabilitative services (including Habilitative Services):
- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.

See also Benefits for Cleft Lip and Cleft Palate.
17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
- The facility charge for use of the emergency room and supplies.

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

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

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

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

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

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

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

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

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

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

**Other**

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

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

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

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

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

28. Dental Treatment.
   Dental treatment when services are performed by a Physician and limited to the following:
   - Injury to Sound, Natural Teeth.

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

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

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

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

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. See Benefits for Mastectomies, Prosthetic Devices and Reconstructive Surgery.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 7: Mandated Benefits

Benefits for Outpatient Services

Benefits will be provided for treatment performed outside a Hospital for any Injury or Sickness as defined in the policy provided that such treatment would be covered on an Inpatient basis and is provided by a health care provider whose services would be covered under the Policy if the treatment were performed in a Hospital. Treatment of the Injury or Sickness must be a Medical Necessity and must be provided as an alternative to Inpatient treatment in a Hospital. Reimbursement is limited to amounts that are Usual and Customary for the treatment or services.

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

Benefits for Procedures Involving Bones or Joints of the Jaw and Facial Region

Benefits will be paid the same as any other Injury or Sickness for diagnostic or surgical procedures involving bones or joints of the jaw and facial region, if, under accepted medical standards, such procedure or surgery is Medically Necessary to treat conditions caused by Injury, Sickness or congenital or developmental deformity.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.
Benefits for Postdelivery Care for a Mother and Her Newborn Infant

Benefits will be paid the same as any other Sickness for postdelivery care for a mother and her Newborn Infant. Benefits for postdelivery care shall include a postpartum assessment and newborn assessment and may be provided at the Hospital, at licensed birth centers, at the Physician's office, at an outpatient maternity center, or in the home by a qualified licensed health care professional trained in mother and baby care. Benefits shall include physical assessment of the newborn and mother, and the performance of any Medically Necessary clinical tests and immunizations in keeping with prevailing medical standards.

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

Benefits for Diabetes

Benefits will be provided for all medically appropriate and necessary equipment, supplies, and diabetes outpatient self-management training and educational services used to treat diabetes, if the patient’s treating Physician or a Physician who specializes in the treatment of diabetes certifies that such services are necessary. Diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified diabetes educator or a board-certified endocrinologist. Nutrition counseling must be provided by a licensed dietitian.

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 Sickness for a mammogram according to the following guidelines:

1. One baseline mammogram for women age thirty-five to thirty-nine, inclusive.
2. A mammogram for women age forty to forty-nine, inclusive, every 2 years or more frequently based on the patient’s Physician’s recommendation.
3. A mammogram every year for women age fifty and over.
4. One or more mammograms a year upon a Physician’s recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.
5. Benefits are paid, with or without a Physician prescription, if the Insured obtains a mammogram in an office, facility, or health testing service that uses radiological equipment registered with the Department of Health and Rehabilitative Services for breast-cancer screening.

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

Benefits for Mastectomies, Prosthetic Devices and Reconstructive Surgery

Benefits will be paid the same as any other Sickness for Mastectomy, prosthetic devices, and Reconstructive Surgery incident to the Mastectomy. Breast Reconstructive Surgery must be in a manner chosen by the treating Physician, consistent with prevailing medical standards, and in consultation with the patient.

"Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician, and the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts.

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

Benefits for Post-Surgical Mastectomy Care

Benefits will be paid the same as any other Sickness for outpatient postsurgical follow-up care in keeping with prevailing medical standards by a Physician qualified to provide postsurgical mastectomy care. The treating Physician, after consultation with the Insured, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the Hospital, treating Physician’s office, outpatient center, or home of the Insured.

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

Benefits will be paid the same as any other Sickness for the Medically Necessary diagnosis and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism and individuals who have a family history of osteoporosis.

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

Benefits for Child Health Assurance

The benefits applicable for Dependent children shall include coverage for Child Health Supervision Services from the moment of birth to 16 years of age.

“Child Health Supervision Services” means Physician-delivered or Physician-supervised services which shall include as the minimum benefit coverage for services delivered at the intervals and scope stated below:

Child Health Supervision Services shall include periodic visits which shall include a history, a physical examination, a developmental assessment and anticipatory guidance, and appropriate immunizations and laboratory tests. Such services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Minimum benefits are limited to one visit payable to one provider for all services provided at each visit.

Benefits shall not be subject to the Deductible, but are subject to all Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Benefits for Cleft Lip and Cleft Palate

Benefits will be paid the same as any other Sickness for a child under the age of 18 for treatment of cleft lip and cleft palate. The benefit will include medical, dental, speech therapy, audiology, and nutrition services if such services are prescribed by the treating Physician and such Physician certifies that such services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

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

Benefits for Newborn Infant, Adopted or Foster Child

Newborn Infant. All health insurance benefits applicable for children will be payable with respect to a child born to the Named Insured or Dependents after the Effective Date and while the coverage is in force, from the moment of birth. However, with respect to a Newborn Infant of a Dependent other than the Insured Person’s spouse, the coverage for the Newborn Infant terminates 18 months after the birth of the Newborn Infant. The coverage for Newborn Infant consists of coverage for Injury or Sickness including necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation cost of the newborn to and from the nearest available facility appropriately staffed and equipped to treat the newborn’s condition, when such transportation is certified by the attending Physician as necessary to protect the health and safety of the Newborn Infant. The coverage of such transportation may not exceed the Usual and Customary Charges.

The Insured may notify the Company, in writing of the birth of the child not less than 30 days after the birth. If timely notice is given, the Company may not charge an additional premium for coverage of the Newborn Infant for the duration of the notice period. If timely notice is not given, the Company may charge the applicable additional premium from the date of birth. The Company will not deny coverage for a child due to failure to timely notify the Company of the child.

Adopted or Foster Child. The Named Insured’s adopted child or foster child will be covered to the same extent as other Dependents from the moment of placement in the residence of the Named Insured. In the case of a newborn adopted child, coverage begins at the moment of birth and applies as for a newborn infant defined above if a written agreement to adopt such child has been entered into by the Named 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 Named Insured’s residence. The Insured may notify the Company, in writing, of the adopted or foster child not less than 30 days after placement or adoption. If timely notice is given, the Company may not charge an additional premium for coverage of such child for the duration of the notice period. If timely notice is not given, the Company may charge the applicable additional premium from the date of adoption or placement. The Company will not deny coverage for a child due to failure to timely notify the Company of such child.
Benefits will also be provided for a foster child or other child placed in court-ordered temporary or other custody of the Insured from the moment of placement.

**Benefits for Hospital Dental Procedures**

Benefits will be paid the same as any other Sickness for general anesthesia and hospitalization services for dental treatment or surgery that is considered necessary when the dental condition is likely to result in a medical condition if left untreated. The necessary dental care shall be provided to an Insured who:

1. Is under 8 years of age and is determined by a licensed dentist, and the child’s Physician to require necessary dental treatment in a Hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or
2. Has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or ambulatory surgical center.

This benefit does not include the diagnosis or treatment of dental disease.

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

**Benefits for Medical Foods**

Benefits will be paid for the Usual and Customary Charges for prescription and non-prescription enteral formulas for home use, for which a Physician has written an order and which is Medically Necessary for the treatment of inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism, as well as malabsorption originating from Congenital Conditions present at birth or acquired during the neonatal period. Coverage for inherited disease of amino acids and organic acids includes food products modified to be low protein, for any Insured Person through the age of 24.

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

**Section 8: Excess Provision**

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

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

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

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

**Section 9: Student Health Center (SHC) Referral Required**

**STUDENTS ONLY**

**OUTPATIENT SERVICES ONLY**

The student must use the services of the Health Center first where outpatient treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each Injury or Sickness per Policy Year.

A SHC referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. The student must return to SHC for necessary follow-up care.
2. When the Student Health Center is closed.
3. When service is rendered at another facility during break or vacation periods.
4. Medical care received when the student is more than 25 miles from campus.
5. Medical care obtained when a student is no longer able to use the SHC due to a change in student status.
6. Maternity, obstetrical and gynecological care.
Dependents are not eligible to use the SHC and therefore are exempt from the above limitations and requirements.

Section 10: Continuation Privilege

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

Application must be made and premium must be paid directly to UnitedHealthcare Student Resources and be received within 14 days after the expiration date of the Insured's coverage. For further information on the Continuation Privilege, please contact UnitedHealthcare Student Resources.

Section 11: Definitions

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

COMPLICATION OF PREGNANCY means one or more of the following: 1) conditions requiring Hospital Confinement (when pregnancy is not terminated), whose diagnosis are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct Complication of Pregnancy; and 2) non-elective cesarean section, ectopic pregnancy which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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

DEPENDENT means the legal spouse of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.
The Named Insured may continue to cover a dependent child to the end of the calendar year in which the Dependent reaches age 30, if the Dependent is all of the following:

1. Is unmarried and does not have any dependents of his/her own.
2. Is a resident of the state of Florida or a full-time or part-time student.
3. Is not covered under any other group or blanket health insurance policy or is not entitled to benefits under Title XVIII of the Social Security Act.

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).

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

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

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

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

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

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

**HOSPITAL** means an institution: 1) licensed as a hospital and operated pursuant to law; and 2) primarily and continuously engaged in providing or operating, either on its premises or in facilities controlled by the hospital, under the supervision of a staff of duly licensed Physicians, medical, diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an outpatient basis for which a charge is made; and, 3) which provides 24 hour nursing services by or under the supervision of Registered Nurses (R.N.’s).

Hospital also means a licensed hospital which is accredited by the Joint Commission on the Accreditation of Hospitals, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities. No claim for payment shall be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability.

The term hospital shall also include licensed birth centers.

For medical care or treatment of a Dependent child, hospital also means a nonprofit, licensed hospital which: 1) provides diagnosis, treatment, or care for patients whose physical functions or movements are impaired by accident, disease or
congenital deformity; 2) accepts patients for treatment without regard to race, color, national origin, sex, religion, or affiliation; 3) does not have facilities for major surgery; and 4) provides treatment and care primarily of a charitable nature.

The term hospital shall not be inclusive of: 1) any military or veteran’s hospital or soldier’s home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces; 2) convalescent homes, convalescent, rest, or nursing facilities; or 3) facilities for the aged, drug addicts or alcoholics and those primarily custodial, educational or rehabilitory care.

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

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

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

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

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

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

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

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

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

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

1. Death.
3. Serious impairment of bodily functions.
4. Serious and permanent 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.

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

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

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

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

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

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

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

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

1. The Policy.
2. The Policyholder Application.
4. The Schedule of Benefits.
5. Endorsements.
6. Riders.
7. Amendments.

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

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

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

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.
SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under the Policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to the Policy’s Effective Date will be considered a sickness under the Policy.

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

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

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

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Insured unable to actively attend classes. A Totally Disabled Dependent is one who is unable to perform all activities usual for a person of that age.

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

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

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

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

Section 12: Exclusions and Limitations

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

1. Acupuncture.
2. Learning disabilities.
5. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Correct deformity caused by birth defects or growth defects.
6. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
7. Elective Surgery or Elective Treatment, except cosmetic surgery made necessary as the result of a covered Injury or to correct a disorder of a normal bodily function.
8. Elective abortion.
9. Foot care for the following:
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).
This exclusion does not apply to preventive foot care for Insured Persons with diabetes.

10. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process. This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.
   - Benefits for Cleft Lip and Cleft Palate.
   - Benefits for Child Health Assurance.
   - Benefits for Newborn Infant, Adopted or Foster Child.


12. 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.

13. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.

14. Injury sustained while:
   - Participating in any intercollegiate or professional sport, contest or competition.
   - Traveling to or from such sport, contest or competition as a participant.
   - Participating in any practice or conditioning program for such sport, contest or competition.

15. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting, except in self-defense.

16. Prescription Drugs, services or supplies as follows:
   - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other nonmedical substances, regardless of intended use, except as specifically provided in the Policy.
   - Immunization agents, except as specifically provided in the Policy.
   - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
   - Products used for cosmetic purposes.
   - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
   - Anorectics - drugs used for the purpose of weight control.
   - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
   - Growth hormones.
   - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

17. Reproductive/Infertility services for the following:
   - Fertility tests.
   - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
   - Premarital examinations.
   - Impotence, organic or otherwise.
   - Reversal of sterilization procedures.

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 Physician services, soft lenses or sclera shells for the treatment of aphakic patients.
   - To initial glasses or contact lenses following cataract surgery.
   - To benefits specifically provided in Pediatric Vision Services.
   - To benefits specifically provided in Benefits for Newborn Infant, Adopted or Foster Child.
   - To benefits specifically provided in Benefits for Child Health Assurance.

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

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

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

22. Sleep disorders.

23. 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.
24. Supplies, except as specifically provided in the Policy.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

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

In the event of Injury or Sickness, students should:

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

Submit the above information to the Company by mail:

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

Section 14: General Provisions

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

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid within 45 days after receipt of due written proof of such loss. If a claim or a portion of a claim is contested by the Company, the Insured shall be notified, in writing, within 45 days after receipt of the claim. The notice shall identify the contested portion of the claim and the reasons for contesting the claim. Upon receipt of the additional information requested, the Company shall pay or deny the contested claim or portion of the claim within 60 days. The Company shall pay or deny any claim no later than 120 days after receipt of the claim. To calculate the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. All overdue payments shall bear simple interest at the rate of 10 percent (10%) per year.

Upon written notification by the Insured, the Company shall investigate any claim of improper billing by the Physician, Hospital or other health care provider. The Company shall determine if the Insured was properly billed for those procedures and services actually received. If determined by the Company that the Insured has been improperly billed, the Company will notify the Insured and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the Insured, the Company shall pay to the Insured 20 percent (20%) of the amount of the reduction up to a maximum of five hundred dollars ($500.00).
PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Loss-of-life benefits are payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to the Insured's estate. Any other benefits unpaid at death may be paid, at the Company's option, either to the Insured's beneficiary or estate. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

CHANGE OF BENEFICIARY: The Insured can change the beneficiary any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the Policy unless the designation of the beneficiary is irrevocable.

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

COVERAGE FOR THE HANDICAPPED: The Company shall not refuse to provide or charge unfairly discriminatory rates for health insurance coverage for a person solely because the person is mentally or physically handicapped. Nothing in this provision shall be construed to require the Company to provide insurance coverage against a handicap which the Insured Person has already sustained.

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

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear. Any such right of subrogation or reimbursement provided to the Company under the policy shall not apply or shall be limited to the extent that the Florida Statutes or the courts of Florida eliminate or restrict such rights.

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

Section 15: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL

Standard Internal Appeal

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

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

Please contact the Customer Service Department at 888-224-4846 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare StudentResources, PO Box 809025, Dallas, TX 75380-9025.

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

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

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

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:
1. Any new or additional evidence considered by the Company in connection with the grievance; and
2. Any new or additional rationale upon which the decision was based.

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

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative as follows:
1. For a Prospective Review, the notice shall be made no later than 30 days after the Company’s receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 60 days after the Company’s receipt of the grievance.

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

The written notice of Final Adverse Determination for the Internal Review shall include:
1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company’s original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company’s standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person’s benefit request;
d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;

e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;

f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;

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

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

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

**Expedited Internal Review**

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

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

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or

2. Would, in the opinion of a Physician with knowledge of the Insured Person’s medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

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

**Expedited Internal Review Process**

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

1. Involving Urgent Care Requests; and

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

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

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

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

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

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

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.
RIGHT TO EXTERNAL INDEPENDENT REVIEW

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

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an External Independent Review.

Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Company. Upon request of an External Review, the Company shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

Where to Send External Review Requests

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

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

Standard External Review (SER) Process

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

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

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

6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.

7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

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

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

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

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

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

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

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

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

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Company.
2. Within 5 business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
   a. The individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
   b. The recommended or requested health care services or treatment:
      • Is a Covered Medical Expense under the Insured Person’s Policy except for the Company’s determination that the service or treatment is experimental or investigational for a particular medical condition; and
      • Is not explicitly listed as an Exclusion or Limitation under the Insured Person’s Policy;
   c. The Insured Person’s treating Physician has certified that one of the following situations is applicable:
      • Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      • Standard health care services or treatments are not medically appropriate for the Insured Person;
      • There is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. The Insured Person’s treating Physician:
      • Has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician’s opinion, than any available standard health care services or treatments; or
      • Who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person’s condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
   e. The Insured Person has exhausted the Company’s Internal Appeal Process; and
   f. The Insured Person has provided all the information and forms necessary to process the request.
3. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
   a. If the request is not complete, the Company’s response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within 1 business day:
   a. Assign an IRO from the Commissioner’s approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
5. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company’s failure to provide the documents and information will not delay the SEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
   b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
   c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
8. After completion of the IRO’s review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

**Expedited Experimental or Investigational Treatment External Review (EEIER) Process**
An Insured Person, or an Insured Person’s Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review when:

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

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

COL-17-FL CERT 27
b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.

10. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 5 calendar days after being selected by the IRO.

11. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.

12. Upon receipt of the IRO’s notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

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

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

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

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

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

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

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

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

**Urgent Care Request** means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
2. In the opinion of a physician with knowledge of the Insured Person’s medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or Retrospective Review.

Questions Regarding Appeal Rights
Contact Customer Service at 1-888-224-4846 with questions regarding the Insured Person’s rights to an Internal Appeal and External Review.

Section 16: Online Access to Account Information

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

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

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

Section 17: ID Cards

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

Section 18: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating healthcare or Mental Health providers, find contact information for the provider’s office or facility, and locate the provider’s office or facility on a map.
- Find My Claims – view claims received within the past 120 days for both the primary Insured and covered Dependents; includes provider, date of service, status, claim amount and amount paid.
Section 19: Important Company Contact Information

The Policy is Underwritten by:

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, Texas 75380-9025
1-888-224-4846
Web site: www.uhcsr.com

Sales/Marketing Services:
UnitedHealthcare StudentResources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
E-mail: info@uhcsr.com

Customer Service:
888-224-4846
(Customer Services Representatives are available Monday - Friday, 7:00 a.m. – 7:00 p.m. (Central Time))
Schedule of Benefits

University of Tampa

2017-629-1

METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 89.88%

Injury and Sickness Benefits

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

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Preferred Provider</td>
<td>$2,500 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td></td>
<td>The Deductible will not be applied until the Company has paid $2,500 in Covered Medical Expenses.</td>
</tr>
<tr>
<td>Deductible Out-of-Network</td>
<td>$6,500 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td></td>
<td>The Deductible will not be applied until the Company has paid $2,500 in Covered Medical Expenses.</td>
</tr>
<tr>
<td>Coinsurance Preferred Provider</td>
<td>80% to $2,500, Deductible applies after $2,500, then 100% thereafter</td>
</tr>
<tr>
<td>Coinsurance Out-of-Network</td>
<td>50% to $2,500, Deductible applies after $2,500, then 70% thereafter</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Provider</td>
<td>$6,350 (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Provider</td>
<td>$12,700 (For all Insureds in a Family, Per Policy Year)</td>
</tr>
</tbody>
</table>

The Company will pay Covered Medical Expenses incurred at 80% for Preferred Providers and 50% for Out-of-Network Providers up to $2,500 before the Insured Person is responsible for satisfaction of the $2,500 Preferred Provider Deductible and $6,500 Out-of-Network Deductible. After the Company pays $2,500, the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at 100% for Preferred Providers and 70% for Out-of-Network Providers.

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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

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

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

Note: No benefits will be paid for services designated as “No Benefits” in the Schedule.

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

...
<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Surgery</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon Fees</td>
<td>50% of Preferred Allowance</td>
<td>50% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Registered Nurse’s Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician’s Visits</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Pre-admission Testing</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Payable within 7 working days prior to admission.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day Surgery Miscellaneous</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Assistant Surgeon Fees</td>
<td>50% of Preferred Allowance</td>
<td>50% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician’s Visits</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>See also Benefits for Cleft Lip and Cleft Palate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Medical Emergency Expenses</strong></td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td><em>The Copay will be waived if admitted to the Hospital.</em></td>
<td>$100 Copay per visit</td>
<td>$100 Copay per visit</td>
</tr>
<tr>
<td><em>The Copay per visit is in addition to the Policy Deductible.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic X-ray Services</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Laboratory Procedures</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Tests &amp; Procedures</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Injections</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td><em>UnitedHealthcare Pharmacy (UHCP), $20 Copay per prescription Tier 1 $30 Copay per prescription Tier 2 $60 Copay per prescription Tier 3 up to a 31-day supply per prescription</em></td>
<td>No Benefits</td>
</tr>
<tr>
<td><em>See UHCP Prescription Drug Benefit Rider for additional information.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge).</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90-day supply.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Student Health Center:</em></td>
<td><em>$10 Copay for generic drug $15 Copay for brand-name drug up to a 31-day supply maximum per prescription.</em></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Consultant Physician Fees</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Dental Treatment</strong></td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td><em>Benefits paid on Injury to Sound, Natural Teeth only.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Illness Treatment</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Other</td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Maternity</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Complications of Pregnancy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Elective Abortion</td>
<td>No Benefits</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>100% of Preferred Allowance</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Reconstructive Breast Surgery Following Mastectomy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Diabetes Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Outpatient Facility or Clinic</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Approved Clinical Trials</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Pediatric Dental and Vision Services</td>
<td>See riders attached for Pediatric Dental and Vision Services benefits</td>
<td>See riders attached for Pediatric Dental and Vision Services benefits</td>
</tr>
</tbody>
</table>

Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.
UNITEDHEALTHCARE INSURANCE COMPANY

POLICY RIDER

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

President

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

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

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

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

Covered Dental Services

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

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

Pre-Treatment Estimate

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

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

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

Pre-Authorization

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

Section 2: Benefits for Pediatric Dental Services

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

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

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

Network Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider’s billed charge. The Company’s negotiated rate with the provider is ordinarily lower than the provider’s billed charge.
A Network provider cannot charge the Insured Person or the Company for any service or supply that is not Necessary as determined by the Company. If the Insured Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Insured Person. However, these charges will not be considered Covered Dental Services and benefits will not be payable.

**Non-Network Benefits:**

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

**Dental Services Deductible**

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

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

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

**Benefits**

Dental Services Deductibles are calculated on a Policy Year basis.

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

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

**Benefit Description**

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
</tbody>
</table>

**Diagnostic Services - (Subject to payment of the Dental Services Deductible.)**

<table>
<thead>
<tr>
<th>Evaluations (Checkup Exams)</th>
<th>50%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0120 - Periodic oral evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0140 - Limited oral evaluation - problem focused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0150 - Comprehensive oral evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0180 - Comprehensive periodontal evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D0160 - Detailed and extensive oral evaluation - problem</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
</tbody>
</table>

**Network Benefits**

**Non-Network Benefits**

### Intraoral Radiographs (X-ray)

*Limited to 2 series of films per 12 months.*

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Complete series (including bitewings)</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first film</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical - each additional film</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal film</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### The following services are not subject to a frequency limit.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0270</td>
<td>Bitewings - single film</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two films</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four films</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Any combination of the following services is limited to 2 series of films per 12 months.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0330</td>
<td>Panoramic radiograph image</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Limited to 1 time per 36 months.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0340</td>
<td>Cephalometric X-ray</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0350</td>
<td>Oral/Facial photographic images</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0391</td>
<td>Interpretation of diagnostic images</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Preventive Services - (Subject to payment of the Dental Services Deductible.)

**Dental Prophylaxis (Cleanings)**

*The following services are limited to 2 times every 12 months.*

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1110</td>
<td>Prophylaxis - adult</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>------------------</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Benefit</td>
<td>are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>D1120 - Prophylaxis - child</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are limited to 2 times every 12 months.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1206 and D1208 - Fluoride</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants (Protective Coating)</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>The following services are limited to once per first or second permanent molar every 36 months.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1351 - Sealant - per tooth - unrestored permanent molar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers (Spacers)</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1510 - Space maintainer - fixed - unilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1515 - Space maintainer - fixed - bilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1520 - Space maintainer - removable - unilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1525 Space maintainer - removable bilateral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1550 - Re-cementation of space maintainer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam Restorations (Silver Fillings)</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2140 - Amalgams - one surface, primary or permanent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2150 - Amalgams - two surfaces, primary or permanent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2160 - Amalgams - three</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td></td>
</tr>
<tr>
<td>surfaces, primary or permanent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2161 - Amalgams - four or more surfaces, primary or permanent</td>
<td></td>
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<td></td>
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<tr>
<td><strong>Composite Resin Restorations</strong></td>
<td></td>
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<td></td>
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<tr>
<td><em>(Tooth Colored Fillings)</em></td>
<td></td>
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<tr>
<td><em>The following services are not subject to a frequency limit.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2330 - Resin-based composite - one surface, anterior</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D2331 - Resin-based composite - two surfaces, anterior</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2332 - Resin-based composite - three surfaces, anterior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Crowns/Inlays/Onlays</strong> - <em>(Subject to payment of the Dental Services Deductible.)</em></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><em>The following services are subject to a limit of 1 time every 60 months.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2542 - Onlay - metallic - two surfaces</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D2543 - Onlay - metallic - three surfaces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2544 - Onlay - metallic - four surfaces</td>
<td></td>
<td></td>
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<tr>
<td>D2740 - Crown - porcelain/ceramic substrate</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2750 - Crown - porcelain fused to high noble metal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2751 - Crown - porcelain fused to predominately base metal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2752 - Crown - porcelain fused to noble metal</td>
<td></td>
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<tr>
<td>D2780 - Crown - 3/4 case high noble metal</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2781 - Crown - 3/4 cast predominately base metal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2783 - Crown - 3/4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td></td>
</tr>
<tr>
<td>porcelain/ceramic</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2790 - Crown - full cast high noble metal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2791 - Crown - full cast predominately base metal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2792 - Crown - full cast noble metal</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2794 Crown – titanium</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2929 – Prefabricated porcelain crown - primary</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>D2930 Prefabricated stainless steel crown - primary tooth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2931 - Prefabricated stainless steel crown - permanent tooth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2510 Inlay - metallic - one surface</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2520 - Inlay - metallic - two surfaces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2530 - Inlay - metallic - three surfaces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2910 - Re-cement inlay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2920 - Re-cement crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D2940 - Protective restoration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is limited to 1 time per tooth every 60 months.</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D2950 - Core buildup, including any pins</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is limited to 1 time per tooth every 60 months.</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D2951 - Pin retention - per tooth, in addition to Crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D2954 - Prefabricated post and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td></td>
</tr>
<tr>
<td>core in addition to crown</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>The following services are not subject to a frequency limit.</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2980 - Crown repair necessitated by restorative material failure</td>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>D2981 – Inlay repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2982 – Onlay repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2983 – Veneer repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2990 – Resin infiltration/smooth surface</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Endodontics - (Subject to payment of the Dental Services Deductible.)**

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>The following service is not subject to a frequency limit.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3220 - Therapeutic pulpotomy (excluding final restoration)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><em>The following service is not subject to a frequency limit.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3222 - Partial pulpotomy for Apexogenesis - Permanent tooth with incomplete root development</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><em>The following services are not subject to a frequency limit.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3230 - Pulpal therapy (resorbable filling) - anterior. primary tooth (excluding final restoration)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><em>The following services are not subject to a frequency limit.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D3310 - Anterior root canal (excluding final restoration)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3320 - Bicuspid root canal (excluding final restoration)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3330 - Molar root canal (excluding final restoration)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td></td>
</tr>
<tr>
<td>D3346 - Retreatment of previous root canal therapy - anterior</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3347 - Retreatment of previous root canal therapy - bicuspid</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3348 - Retreatment of previous root canal therapy - molar</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3351 - Apexification/recalcification - initial visit</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3352 - Apexification/recalcification - interim medication replacement</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3353 - Apexification/recalcification - final visit</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3354 - Pulpal Regeneration</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3410 - Apicoectomy/periradicular - anterior</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3421 - Apicoectomy/periradicular - bicuspid</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3425 - Apicoectomy/periradicular - molar</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3426 - Apicoectomy/periradicular - each additional root</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3450 - Root amputation - per root</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D3920 - Hemisection (including</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
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<td>----------------------</td>
</tr>
<tr>
<td>any root removal), not including root canal therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Periodontics - (Subject to payment of the Dental Services Deductible.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to a frequency of 1 every 36 months.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4210 - Gingivectomy or gingivoplasty - four or more teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4211 - Gingivectomy or gingivoplasty - one to three teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4212 - Gingivectomy or gingivoplasty – with restorative procedures – per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to 1 every 36 months.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4240 - Gingival flap procedure, four or more teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>The following service is not subject to a frequency limit.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4249 - Clinical crown lengthening - hard tissue</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to 1 every 36 months.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4260 - Osseous surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or tooth bounded spaces per quadrant</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4263 - Bone replacement graft – first site in quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4270 - Pedicle soft tissue graft procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4271 - Free soft tissue graft procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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<tr>
<td>-----------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4273 - Subepithelial connective tissue graft procedures, per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4275 - Soft tissue allograft</td>
<td></td>
<td></td>
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<tr>
<td>D4277 - Free soft tissue graft - first tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4278 - Free soft tissue graft - additional teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to 1 time per quadrant every 24 months.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4341 - Periodontal scaling and root planning - four or more teeth per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4342 - Periodontal scaling and root planning - one to three teeth per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following service is limited to a frequency to 1 per lifetime.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following service is limited to 4 times every 12 months in combination with prophylaxis.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D4910 - Periodontal maintenance</td>
<td></td>
<td></td>
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<tr>
<td><strong>Removable Dentures - (Subject to payment of the Dental Services Deductible.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following services are limited to a frequency of 1 every 60 months.</strong></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D5110 - Complete denture - maxillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5120 - Complete denture - mandibular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5130 - Immediate denture - maxillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5140 - Immediate denture - mandibular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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</tr>
<tr>
<td><strong>Benefit Description and Limitations</strong></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>D5211 - Mandibular partial denture - resin base</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D5212 - Maxillary partial denture - resin base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5213 - Maxillary partial denture - cast metal framework with resin denture base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5214 - Mandibular partial denture - cast metal framework with resin denture base</td>
<td></td>
<td></td>
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<tr>
<td>D5281 - Removable unilateral partial denture - one piece cast metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D5410 - Adjust complete denture - maxillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5411 - Adjust complete denture - mandibular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5421 - Adjust partial denture - maxillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5422 - Adjust partial denture - mandibular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5510 - Repair broken complete denture base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5520 - Replace missing or broken teeth - complete denture</td>
<td></td>
<td></td>
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<tr>
<td>D5610 - Repair resin denture base</td>
<td></td>
<td></td>
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<tr>
<td>D5620 - Repair cast framework</td>
<td></td>
<td></td>
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<tr>
<td>D5630 - Repair or replace broken clasp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5640 - Replace broken teeth - per tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5650 - Add tooth to existing partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D5660 - Add clasp to existing partial denture</td>
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</tr>
</tbody>
</table>

The following services are limited to rebasing performed more than 6 months after the
<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</th>
<th>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Initial insertion with a frequency limitation of 1 time per 12 months.</em></td>
<td>D5710 - Rebase complete maxillary denture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5720 - Rebase maxillary partial denture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5721 - Rebase mandibular partial denture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5730 - Reline complete maxillary denture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5731 - Reline complete mandibular denture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5740 - Reline maxillary partial denture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5741 - Reline mandibular partial denture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5750 - Reline complete maxillary denture (laboratory)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5751 - Reline complete mandibular denture (laboratory)</td>
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<tr>
<td></td>
<td>D5752 - Reline complete mandibular denture (laboratory)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5760 - Reline maxillary partial denture (laboratory)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5761 - Reline mandibular partial denture (laboratory) - rebase/reline</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5762 - Reline mandibular partial denture (laboratory)</td>
<td></td>
</tr>
<tr>
<td><em>The following services are not subject to a frequency limit.</em></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>D5850 - Tissue conditioning (maxillary)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D5851 - Tissue conditioning (mandibular)</td>
<td></td>
</tr>
</tbody>
</table>

*Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)*

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</th>
<th>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The following services are not subject to a frequency limit.</em></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>D6210 - Pontic - case high</td>
<td></td>
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<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
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<tr>
<td>noble metal</td>
<td></td>
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<tr>
<td>D6211 - Pontic - case</td>
<td></td>
<td></td>
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<tr>
<td>predominately base metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6212 - Pontic - cast noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6214 - Pontic - titanium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6240 - Pontic - porcelain fused to high noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6241 - Pontic - porcelain fused to predominately base metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6242 - Pontic - porcelain fused to noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6245 - Pontic - porcelain/ceramic</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

*The following services are not subject to a frequency limit.*

D6545 - Retainer - cast metal for resin bonded fixed prosthesis
D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis

*The following services are not subject to a frequency limit.*

D6519 - Inlay/onlay - porcelain/ceramic
D6520 - Inlay - metallic - two surfaces
D6530 - Inlay - metallic - three or more surfaces
D6543 - Onlay - metallic - three surfaces
D6544 - Onlay - metallic - four or more surfaces

*The following services are limited to 1 time every 60 months.*

D6740 - Crown - porcelain/ceramic
D6750 - Crown - porcelain fused to high noble metal

50%     50%
<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Description and Limitations</strong></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>D6751 - Crown - porcelain fused to predominately base metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6752 - Crown - porcelain fused to noble metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6780 - Crown - 3/4 cast high noble metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6781 - Crown - 3/4 cast predominately base metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6782 - Crown - 3/4 cast noble metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6783 - Crown - 3/4 porcelain/ceramic</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6790 - Crown - full cast high noble metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6791 - Crown - full cast predominately base metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6792 - Crown - full cast noble metal</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6930 - Re-cement or re-bond fixed partial denture</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Oral Surgery - (Subject to payment of the Dental Services Deductible.)</strong></td>
<td></td>
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</tr>
<tr>
<td>D7140 - Extraction, erupted tooth or exposed root</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7210 - Surgical removal of erupted tooth requiring elevation of mucoperioteal flap and removal of bone and/or section</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
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<tr>
<td>of tooth</td>
<td></td>
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<tr>
<td>D7220 - Removal of impacted tooth - soft tissue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7230 - Removal of impacted tooth - partially bony</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7240 - Removal of impacted tooth - completely bony</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7241 - Removal of impacted tooth - complete bony with unusual surgical complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7250 - Surgical removal or residual tooth roots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7251 - Coronectomy - intentional partial tooth removal</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following service is not subject to a frequency limit.</strong></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td>D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td></td>
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</tr>
<tr>
<td><strong>The following service is not subject to a frequency limit.</strong></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td>D7280 - Surgical access of an unerupted tooth</td>
<td></td>
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</tr>
<tr>
<td><strong>The following services are not subject to a frequency limit.</strong></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
</tr>
<tr>
<td>D7310 - Alveoloplasty in conjunction with extractions - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7320 - Alveoloplasty not in conjunction with extractions - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following service is not</strong></td>
<td><strong>50%</strong></td>
<td><strong>50%</strong></td>
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</tbody>
</table>


<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>subject to a frequency limit.</td>
<td></td>
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</tr>
<tr>
<td>D7471 - removal of lateral exostosis (maxilla or mandible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are not subject to a frequency limit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D7510 - Incision and drainage of abscess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7910 - Suture of recent small wounds up to 5 cm</td>
<td></td>
<td></td>
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<tr>
<td>D7921 - Collect - apply autologous product</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7953 - Bone replacement graft for ridge preservation - per site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D7971 - Excision of pericoronal gingiva</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjunctive Services - (Subject to payment of the Dental Services Deductible.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D9110 - Palliative (Emergency) treatment of dental pain - minor procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered only when clinically Necessary.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D9220 - Deep sedation/general anesthesia first 30 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9221 - Dental sedation/general anesthesia each additional 15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9241 - Intravenous conscious sedation/analgesia - first 30 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9610 - Therapeutic drug injection, by report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
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</tr>
<tr>
<td><strong>Covered only when clinically Necessary</strong></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>The following is limited to 1 guard every 12 months.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D9940 - Occlusal guard</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Implant Procedures - (Subject to payment of the Dental Services Deductible.)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The following services are limited to 1 time every 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D6010 - Endosteal implant</td>
<td></td>
<td></td>
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<tr>
<td>D6012 - Surgical placement of interim implant body</td>
<td></td>
<td></td>
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<tr>
<td>D6040 - Epostal Implant</td>
<td></td>
<td></td>
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<tr>
<td>D6050 - Transosteal implant, including hardware</td>
<td></td>
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<tr>
<td>D6053 - Implant supported complete denture</td>
<td></td>
<td></td>
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<tr>
<td>D6054 - Implant supported partial denture</td>
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<td></td>
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<tr>
<td>D6055 - Connecting bar implant or abutment supported</td>
<td></td>
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<tr>
<td>D6056 - Prefabricated abutment</td>
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<td></td>
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<tr>
<td>D6057 - Custom abutment</td>
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<td></td>
</tr>
<tr>
<td>D6058 - Abutment supported porcelain ceramic crown</td>
<td></td>
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<tr>
<td>D6059 - Abutment supported porcelain fused to high noble metal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6060 - Abutment supported porcelain fused to predominately base metal crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6061 - Abutment supported porcelain fused to noble metal crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6062 - Abutment supported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
<td>------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>cast high noble metal crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6063 - Abutment supported case predominately base metal crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6064 - Abutment supported porcelain/ceramic crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6065 - Implant supported porcelain/ceramic crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6066 - Implant supported porcelain fused to high metal crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6067 - Implant supported metal crown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6072 - Abutment supported retainer for cast high noble metal fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6073 - Abutment supported retainer for predominately base metal fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6074 - Abutment supported retainer for cast metal fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6075 - Implant supported retainer for ceramic fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6076 - Implant supported retainer for porcelain fused to high noble metal fixed partial denture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits</td>
<td>Non-Network Benefits</td>
</tr>
<tr>
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<td>----------------------</td>
</tr>
<tr>
<td>D6077 - Implant supported retainer for cast metal fixed partial denture</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6080 - Implant maintenance procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6090 - Repair implant prosthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6091 - Replacement of semi-precision or precision attachment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6095 - Repair implant abutment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6100 - Implant removal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6101 - Debridement periimplant defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6102 - Debridement and osseous periimplant defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6103 - Bone graft periimplant defect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6104 - Bone graft implant replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D6190 - Implant index</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

All orthodontic treatment must be prior authorized.

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

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>The following services are not subject to a frequency limitation as long as benefits have been prior authorized.</em></td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>D8010 - Limited orthodontic treatment of the primary dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8020 - Limited orthodontic treatment of the transitional dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8030 - Limited orthodontic treatment of the adolescent dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8050 - Interceptive orthodontic treatment of the primary dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8060 - Interceptive orthodontic treatment of the transitional dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8070 - Comprehensive orthodontic treatment of the transitional dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8080 - Comprehensive orthodontic treatment of the adolescent dentition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8210 - Removable appliance therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8220 - Fixed appliance therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8660 - Pre-orthodontic treatment visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8670 - Periodic orthodontic treatment visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D8680 - Orthodontic retention</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section 3: Pediatric Dental Exclusions**

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this rider in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.

6. Any Dental Procedure not directly associated with dental disease.

7. Any Dental Procedure not performed in a dental setting.

8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.

12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.

14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through this rider to the Policy.

16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.

17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.

18. Foreign Services are not covered unless required for a Dental Emergency.

19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.
Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

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

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

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 rider 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:
  o Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  o 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 rider. The definition of Necessary used in this rider relates only to benefits under this rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.
Network - a group of Dental Providers who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Insured Persons. The participation status of providers will change from time to time.

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

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

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

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

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

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

POLICY RIDER

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

[Signature]
President

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Non-Network Benefits:

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

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

Policy Deductible

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

Benefit Description

Benefits

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

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

Frequency of Service Limits

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

Routine Vision Examination

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

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

Post examination procedures will be performed only when materials are required.
Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

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

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

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

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

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

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

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

Benefits include the fitting/evaluation fees and contacts.

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

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

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

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

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Vision Examination or Refraction only in lieu of a complete exam.</strong></td>
<td>Once per year.</td>
<td>100% after a Copayment of $20.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td>Once per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single Vision</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Bifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Trifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Lenticular</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Lens Extras</strong></td>
<td>Once per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Polycarbonate lenses</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>• Standard scratch-resistant coating</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td><strong>Vision Care Service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eyeglass Frames</strong></td>
<td>Once per year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost up to $130.</td>
<td></td>
<td>100%</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $130 - 160.</td>
<td></td>
<td>100% after a Copayment of $15.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $160 - 200.</td>
<td></td>
<td>100% after a Copayment of $30.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $200 - 250.</td>
<td></td>
<td>100% after a Copayment of $50.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost greater than $250.</td>
<td></td>
<td>60%</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Contact Lenses Fitting &amp; Evaluation</strong></td>
<td>Once per year.</td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td></td>
<td></td>
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<tr>
<td>----------------------------------------------------</td>
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<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>• Covered Contact Lens Selection</td>
<td>Limited to a 12 month supply.</td>
<td>100% after a Copayment of $40.</td>
<td></td>
</tr>
<tr>
<td>• Necessary Contact Lenses</td>
<td>Limited to a 12 month supply.</td>
<td>100% after a Copayment of $40.</td>
<td></td>
</tr>
</tbody>
</table>

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060
Section 4: Defined Terms for Pediatric Vision Care Services

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

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

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

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

Vision Care Service - any service or item listed in this rider in Section 1: Benefits for Pediatric Vision Care Services.
UNITEDHEALTHCARE INSURANCE COMPANY

POLICY RIDER

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

[Signature]  
President

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

UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

Benefits for Prescription Drug Products

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

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

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

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used.

The Insured must present their ID card to the Network Pharmacy when the prescription is filled. If the Insured does not present their ID card to the Network Pharmacy, they will need to pay for the Prescription Drug and then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.uhcsr.com and logging in to their online account or by calling Customer Service at 1-855-828-7716.

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

If the Insured does not use a Network Pharmacy, no benefits are available and the Insured will be responsible for paying the full cost for the Prescription Drug.

Copayment and/or Coinsurance Amount

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

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy’s Usual and Customary Fee for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.
For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

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

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

**Supply Limits**

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

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

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

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month’s supply or may require that a minimum amount be dispensed.

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling Customer Service at 1-855-828-7716.

**If a Brand-name Drug Becomes Available as a Generic**

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

**Designated Pharmacies**

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

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Pharmacy, the Insured may opt-out of the Designated Pharmacy program through the Internet at www.uhcsr.com or by calling Customer Service at 1-855-828-7716. If the Insured opts-out of the program and fills their Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, the Insured will be responsible for the entire cost of the Prescription Drug Product.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, no benefits will be paid for that Prescription Drug Product, or, for a Specialty Prescription Drug Product, if the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.
**Specialty Prescription Drug Products**

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

**Notification Requirements**

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

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

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. There may be certain Prescription Drug Products that require the Insured to
notify the Company directly rather than the Insured’s Physician or pharmacist. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.uhcsr.com or by calling Customer Service at 1-855-828-7716.

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

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

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

**Limitation on Selection of Pharmacies**

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

**Coverage Policies and Guidelines**

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

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

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

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

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

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

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

Definitions

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

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

**Designated Pharmacy** means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company’s behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

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

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

Exceptions:

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

**Generic** means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors.
The Insured should know that all products identified as a “generic” by the manufacturer, pharmacy or Insured’s Physician may not be classified as a Generic by the Company.

**Network Pharmacy** means a pharmacy that has:

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

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

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

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

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

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

- Inhalers.
- Insulin.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose monitors.

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

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

**Prescription Drug List Management Committee** means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.
**Prescription Order or Refill** means the directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

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

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

The Insured may determine whether a drug is a Preventive Care Medication through the internet at www.uhcsr.com or by calling Customer Service 1-855-828-7716.

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

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

**Unproven Service(s)** means services, including medications, that are determined not to be effective for the treatment of the medical condition and/or not to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

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

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

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

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

**Additional Exclusions**

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:
1. Coverage for Prescription Drug Products for the amount dispensed (days’ supply or quantity limit) which exceeds the supply limit.

2. Coverage for Prescription Drug Products for the amount dispensed (days’ supply or quantity limit) which is less than the minimum supply limit.

3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven. This exclusion does not apply to drugs prescribed for the treatment of cancer on the ground that the drug is not approved by the United States Food and Drug Administration for a particular indication, if that drug is recognized for treatment of that indication in an authoritative compendium identified by the Secretary of the United States Department of Health and Human Services and recognized by the federal Centers for Medicare and Medicaid, or in studies published in a United States peer-reviewed national professional journal.

4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.

5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by the Company’s PDL Management Committee.

6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.)

7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.

8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

11. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
12. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a “biosimilar” is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.

13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

14. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.

15. Diagnostic kits and products.

16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

**Right to Request an Exclusion Exception**

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured’s representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-888-224-4846. The Company will notify the Insured Person of the Company’s determination within 72 hours.

**Urgent Requests**

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

**External Review**

If the Insured Person is not satisfied with the Company’s determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person’s representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-888-224-4846. The Independent Review Organization (IRO) will notify the Insured Person of the determination within 72 hours.

** Expedited External Review**

If the Insured Person is not satisfied with the Company’s determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured’s representative may request an expedited external review by calling 1-888-224-4846 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.
NON-DISCRIMINATION NOTICE

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

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

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

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

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

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

**Online**  [https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf)


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

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

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

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

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

XIN LUÚ Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-260-2723.

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

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


تنبيه: إذا كنت تتحدث العربية (Arabic)، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-260-2723.

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

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

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

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

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

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

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

توجه: اگر زبان شما فارسی (Farsi) است، خدمات امداد زبانی به طور رایگان در اختیار شما می‌باشند. 1-866-260-2723

クープ お知らせ: やだ アップ ヒンディー (Hindi) 言語で ある よう な と アップ の ために 言語 サポート サービス の みを 有する シェルク ウェルビー も あ りです。
クープ ハル 1-866-260-2723

CEEB TOOM: Yog koe baireus Hmoob (Hmong), muaj koe vab txais lus pub dawb rau koe. Thov hu rau 1-866-260-2723.

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

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yánilito, saad bee áka'ánda'awó'ígi, t'áá jík'eh, bee ná'ahóóí'. T'áá shoodí kohji' 1-866-260-2723 hodíilnih.

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