PLEASE NOTE:

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

2012-2013 Student Injury and Sickness Insurance Plan

Designed especially for the students of:

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

UnitedHealthcare®
A UnitedHealth Group Company

201610-1

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $250,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-505-4160. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

Eligibility

All International Students, Law and Graduate students taking 6 or more credit hours (or 3 or more credit hours in the summer) are eligible to enroll in the plan on a voluntary basis. Eligible Dependents of enrolled students may purchase the plan on a voluntary basis.

TABLE OF CONTENTS

PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured 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 Named Insured 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 (as defined) 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; or
2) If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:

    (a) On the date the Named Insured marries the Dependent; or
    (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 policy.

Dependent eligibility expires concurrently with that of the Named Insured.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Named Insured.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid;
2) The date the policy terminates; or
3) The date the Named Insured's coverage terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

GRACE PERIOD: A grace period of thirty-one (31) days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Insured has given the Company written notice of discontinuance.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this 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, or to any authorized agent of the Company 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 180 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

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

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

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

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

RIGHT OF RECOVERY: 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.

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.

CERTIFICATE OF CREDITABLE COVERAGE: A certificate of creditable coverage will be provided to the Insured at the time coverage ceases under the Policy and upon request on behalf of the Insured made no later than 24 months after the

date coverage ended. The certification will be a written certification of the period of creditable coverage of the Insured under the Policy and any waiting period and affiliation period, if applicable, imposed with respect to the Insured for any coverage under the Policy.

PART III
DEFINITIONS

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

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

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.

CREDITABLE COVERAGE means benefits or coverage provided under:

a. A group health plan as defined in G.S. 58-68-25(a)(4b).
b. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise.
c. Part A or part B of title XVIII of the Social Security Act.
d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
e. Chapter 55 of title 10, United States Code.
f. A medical care program of the Indian Health Service or of a tribal organization.
g. A State health benefits risk pool.
h. A health plan offered under chapter 89 of title 5, United States Code.
i. A public health plan (as defined in federal regulations).
j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)).
k. Title XXI of the Social Security Act (State Children's Health Insurance Program).

CUSTODIAL CARE means services that are any of the following:

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

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

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent-children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

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

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

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

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

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.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental Illness or Substance Use Disorder. Hospital includes a duly licensed state tax-supported institution as defined in Statute 58-251.6 of the North Carolina Insurance Code.

IN-NETWORK COVERED MEDICAL EXPENSES means Covered Medical Expenses that are received under the terms of the policy from providers under contract with or approved in advance by the Company and means Medical Emergency services regardless of the status or affiliation of the provider of such services.

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

INJURY means bodily injury which is all of the following:

1) directly and independently caused by specific accidental contact with another body or object.
2) unrelated to any pathological, functional, or structural disorder.
3) a source of loss.
4) treated by a Physician within 30 days after the date of accident.
5) sustained while the Insured Person is covered under this policy.

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

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

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

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

1) Progressive care.

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

MEDICAL EMERGENCY means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to would result in any of the following:

1) Placing the health of an individual, or with respect to a pregnant woman, the health of the women or her unborn child, in serious jeopardy.
2) Serious impairment of bodily functions.
3) Serious dysfunction of any body organ or part.

Medical Emergency services include health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

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 means those services or supplies that are:

1) Provided for the diagnosis, treatment, cure, or relief of a health condition, Sickness, Injury, or disease; and, not for experimental, investigational, or cosmetic purposes, except as allowed for in the Benefits for Cancer Clinical Trials.
2) Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, Sickness, Injury, disease, or its symptoms..
3) Within generally accepted standards of medical care in the community.
4) Not solely for the convenience of the Insured, the Insured's family, or the provider.

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.

For medically necessary services, the Company may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity.

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

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

NEWBORN INFANT, ADOPTED OR FOSTER CHILD means any child born of an Insured while that person is insured under this policy. Such child will be covered under the policy from the moment of birth or placement for the first 31 days after birth or placement. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects or birth abnormalities including treatment of cleft lip and cleft palate,, prematurity and nursery care.

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

If family coverage is in force and no additional premium is required, enrollment/notification of the new Dependent within the specified period of time will not be required nor penalties applied for failure to do so.

OUT-OF-NETWORK COVERED MEDICAL EXPENSES means non-emergency Covered Medical Expenses that are not received according to the terms of the policy including services from affiliated providers that are received without the approval of the Company.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

1) Deductibles.
2) Copays.
3) Expenses that are not Covered Medical Expenses.

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 any form of the following short-term rehabilitation therapies: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

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

PRE-EXISTING CONDITION means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within a twelve-month period immediately preceding the Insured's Effective Date under the policy.

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

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.

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

PART IV
EXTENSION OF BENEFITS AFTER TERMINATION

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

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

PART V

SCHEDULE OF BENEFITS

MEDICAL EXPENSE BENEFITS

CHARLOTTE SCHOOL OF LAW - STUDENT PLAN

2012-201610-1

INJURY AND SICKNESS BENEFITS

Maximum Benefit	**$250,000 (Per Insured Person) (Per Policy Year)**
Deductible Preferred Providers	**$250 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network	**$500 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Providers	**90% except as noted below**
Coinsurance Out-of-Network	**70% except as noted below**
Out-of-Pocket Maximum Preferred Providers	**$3,500 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network	**$7,000 (Per Insured Person, Per Policy Year)**

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 a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expense is incurred 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% up to the policy Maximum Benefit subject to any benefit maximums that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Copays and per service Deductibles and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. 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.

Inpatient	**Preferred Provider**	**Out-of-Network Provider**
Room & Board:	Preferred Allowance	Usual and Customary Charges
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous:	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care:	Paid as any other Sickness	Paid as any other Sickness
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
Surgery:	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing:	Preferred Allowance	Usual and Customary Charges

Outpatient	**Preferred Provider**	**Out-of-Network Provider**
Surgery:	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous:	Preferred Allowance	Usual and Customary Charges
(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance $25 Copay per visit	Usual and Customary Charges
Physiotherapy:	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
(Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.)		
Medical Emergency:	100% of Preferred Allowance $150 Copay per visit	100% of Usual and Customary Charges $150 Deductible per visit
(Copay/per visit Deductible is in addition to the Policy Deductible) (The Copay /per visit Deductible will be waived if admitted to the Hospital.)		
X-rays:	Preferred Allowance	Usual and Customary Charges
Radiation Therapy:	Preferred Allowance	Usual and Customary Charges
Laboratory:	Preferred Allowance	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges
Chemotherapy:	Preferred Allowance	Usual and Customary Charges
***Prescription Drugs:**	UnitedHealthcare Network Pharmacy (UHPS) $15 Copay per prescription for Tier 1 $35 Copay per prescription for Tier 2 $70 Copay per prescription for Tier 3	$15 Deductible per prescription for generic drugs $35 Deductible per prescription for brand name

Other	Preferred Provider	Out-of-Network Provider
Ambulance:	Preferred Allowance	90% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
($1,000 maximum (Per Policy Year)) (Durable Medical Equipment benefits payable under the $1000 maximum are not included in the $250,000 Maximum Benefit.)		
Consultant:	Preferred Allowance	Usual and Customary Charges
Dental:	90% of Usual and Customary Charges	90% of Usual and Customary Charges
($1,000 maximum (Per Policy Year)) (Benefits paid on Injury to Sound, Natural Teeth only. Benefits are not subject to the $250,000 Maximum Benefit.)		
Maternity:	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion:	No Benefits	No Benefits
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Repatriation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
Medical Evacuation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
***AD&D:** *($2,500 - $5,000 maximum)*	Note Below	Note Below
Preventive Care Services:	100% of Preferred Allowance *(No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.)*	Usual and Customary Charges
Diabetes Services: *(See Benefits for Diabetes)*	Paid as any other Sickness	Paid as any other Sickness
Mental Illness Treatment:	Paid as any other Sickness	Paid as any other Sickness
Reconstructive Surgery Following Mastectomy: *(See Benefits for Reconstructive Breast Surgery Following Mastectomy)*	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment:	Paid as any other Sickness	Paid as any other Sickness

MAJOR MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

SHC Referral Required: Yes ( ) No (X) **Continuation Permitted:** Yes ( ) No (X)

( ) 52 Week Benefit Period or **(X) Extension of Benefits**

***Pre Admission Notification:** Yes (X) No ( )

Other Insurance: ( ) Excess Insurance ( ) Excess Motor Vehicle (X) Primary Insurance

*If benefit is designated, see endorsement attached.

PART VI
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. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-4160 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.

"**Network Area**" means the 50 mile radius around the local school campus the Named Insured is attending.

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 (800) 505-4160 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.

NOTICE
The Insured's actual costs for Covered Medical Expenses may exceed the stated Coinsurance or Copayment amount because actual provider charges may not be used to determine Policy and Insured payment obligations.

PART VII
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

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 Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any Coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. 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:

1. **Room and Board Expense:** 1) daily semi-private room rate when confined as an Inpatient; and 2) general nursing care provided and charged by the Hospital.

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

3. **Hospital Miscellaneous Expenses:** 1) when confined as an Inpatient; or 2) as a precondition for being confined as an Inpatient. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 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. **Physiotherapy (Inpatient):** See Schedule of Benefits.

6. **Surgery:** Physician's fees for Inpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.

7. **Assistant Surgeon Fees:** in connection with Inpatient surgery, if provided in the Schedule of Benefits.

8. **Anesthetist Services:** professional services administered in connection with Inpatient surgery.

9. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while an Inpatient; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital, is not covered under this benefit.

10. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the Inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.

12. **Surgery (Outpatient):** Physician's fees for outpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.

13. **Day Surgery Miscellaneous (Outpatient):** 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. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.

14. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

15. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

16. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the Inpatient benefit for Physician's Visits, but not both on the same day. Physician's Visits for preventive care are provided as specified under Preventive Care Services.

17. **Physiotherapy (Outpatient):** benefits are limited to one visit per day. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.

18. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.

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

20. **Radiation Therapy (Outpatient):** See Schedule of Benefits.

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

22. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit: inhalation therapy; infusion therapy; pulmonary therapy; and respiratory therapy. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

23. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

24. **Chemotherapy (Outpatient):** See Schedule of Benefits.

25. **Prescription Drugs (Outpatient):** See Schedule of Benefits.

26. **Ambulance Services:** See Schedule of Benefits.

27. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. Durable medical equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. If more than one prosthetic device can meet the Insured's functional need, benefits are available only for the prosthetic device that meets the minimum specifications for the Insured's needs.. 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.

28. **Consultant Physician Fees:** when requested and approved by the attending Physician.

29. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

30. **Mental Illness Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; and 2) on an outpatient basis including intensive outpatient treatment. Benefits are limited to one visit per day.

31. **Substance Use Disorder Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; 2) on an outpatient basis including intensive outpatient treatment. Benefits are limited to one visit per day.

32. **Maternity:** Same as any other Sickness. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.

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

    Initial screening at first visit:
    1) Pregnancy test: urine human chorionic gonatropin (HCG)
    2) Asymptomatic bacteriuria: urine culture
    3) Blood type and Rh antibody
    4) Rubella
    5) Pregnancy-associated plasma protein-A (PAPPA) (**first trimester only)**
    6) Free beta human chorionic gonadotrophin (hCG) (**first trimester only)**
    7) Hepatitis B: HBsAg
    8) Pap smear
    9) Gonorrhea: Gc culture
    10) Chlamydia: chlamydia culture
    11) Syphilis: RPR
    12) HIV: HIV-ab
    13) Coombs test
    Each visit: Urine analysis
    Once every trimester: Hematocrit and Hemoglobin
    Once during first trimester: Ultrasound
    Once during second trimester
    1) Ultrasound (anatomy scan)
    2) Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a
    Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS)
    Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)
    Once during third trimester: Group B Strep Culture

    Pre-natal vitamins are not covered.

33. **Complications of Pregnancy:** Same as any other Sickness.

34. **Preventive Care Services:** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) 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*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) 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*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

35. **Reconstructive Breast Surgery Following Mastectomy:** same as any other Sickness and in connection with a covered mastectomy. See Benefits for Reconstructive Breast Surgery Following Mastectomy.

36. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.

37. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

38. **Medical Evacuation:** 1) when Hospital Confined for at least three - five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

39. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

PART VIII
MANDATED BENEFITS

BENEFITS FOR EMERGENCY SERVICES

Benefits will be paid the same as any other Sickness or Injury for treatment of a Medical Emergency. The Insured should use emergency services, including calling 911 or other telephone access systems utilized to access pre hospital emergency services when appropriate for treatment of a Medical Emergency.

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

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER

Benefits will be paid the same as treatment to any other joint in the body for the treatment of Temporomandibular Joint Disorder ("TMJ"). Procedures will include splinting and use of intraoral prosthetic appliances to reposition the bones. Non-surgical treatment of TMJ is subject to a lifetime maximum benefit of $3,500. No benefits will be paid for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, root canal or routine dental treatment.

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

BENEFITS FOR CERVICAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for Examinations and Laboratory Tests for the screening for the early detection of cervical cancer. Benefits shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control and will include the examination, laboratory fee, and the Physician's interpretation of the laboratory results.

Reimbursement for the laboratory fee will be made only if the laboratory meets accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Examinations and laboratory tests" means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

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 Low-dose Screening Mammography according to the following guidelines:

1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this benefit, "at risk" means the following:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30.

2. One baseline mammogram for any woman thirty-five through thirty-nine years of age, inclusive.

3. A mammogram every other year for any woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Physician.

4. A mammogram every year for any woman fifty years of age or older.

Reimbursement will be made only if the facility where treatment is rendered meets the mammography accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician's interpretation of the results of the procedure.

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

BENEFITS FOR SURVEILLANCE TESTS FOR WOMEN AT RISK FOR OVARIAN CANCER

Benefits will be paid the same as any other Sickness for Surveillance Tests for women age 25 and older At Risk for Ovarian Cancer.

"At risk for ovarian cancer" means either: a) having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2) testing positive for a hereditary ovarian cancer syndrome.

"Surveillance tests" mean annual screening using: a) transvaginal ultrasound, and 2) rectovaginal pelvic examination.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for Colorectal Cancer Screening. Beginning at age 50, benefits will be provided for non-symptomatic Insured Persons for one of the five screening options below:

1. Yearly fecal occult blood test (FOBT); or
2. Flexible sigmoidoscopy every five (5) years; or
3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years; or
4. Double contract barium enema every five (5) years; or
5. Colonoscopy every ten (10) years.

In addition, upon recommendation of the Physician, medically necessary benefits will be provided for one or more of the screening options, based on American Cancer Society guidelines regarding family history or other factors, regardless of the age of the Insured.

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

BENEFITS FOR PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician.

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING MASTECTOMY

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery following a Mastectomy. Benefits will be paid for all stages and revisions of Reconstructive Breast Surgery performed on a diseased breast, as well as for prostheses and physical complications in all stages of Mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a Mastectomy is covered without regard to the lapse of time between the Mastectomy and the reconstruction upon approval by the treating Physician.

"Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

"Reconstructive breast surgery" means surgery performed as a result of a Mastectomy to re-establish symmetry between the two breasts, and includes reconstruction of the Mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for medically necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures, used to treat

diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician or healthcare professional designated by the Physician.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the Physician treating the Insured involved certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

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

BENEFITS FOR BONE MASS MEASUREMENT

Benefits will be paid the same as any other Sickness for a Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass for Qualified Individuals.

Benefits will be paid for one Bone Mass Measurement every 23 months. Benefits will be paid more frequently when medically necessary. Conditions that may be considered medically necessary include, but are not limited to: 1) monitoring beneficiaries on long-term glucocorticoid therapy of more than three months and 2) to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

"Bone mass measurement" means a scientifically proven radiologic, radioisotopic, or other procedure performed on a Qualified Individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

"Qualified individual" means any one or more of the following:
an individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
an individual with radiographic osteopenia anywhere in the skeleton;
an individual who is receiving long-term glucocorticoid (steroid) therapy;
an individual who primary hyperparathyroidism;
an individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
an individual who has a history of low-trauma fractures; or
an individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

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

BENEFITS FOR PRESCRIPTION CONTRACEPTIVES

If the Policy provides coverages for prescription drugs or devices, benefits will be paid the same as any other prescription drug or device for any contraceptive drug or device including the insertion or removal and any medical examination associated with the use of such contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid the same as any other Sickness for outpatient contraceptive services provided by a Physician.

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

BENEFITS FOR NEWBORN HEARING SCREENING

Benefits will be paid the same as any other Sickness for Physician ordered newborn hearing screening.

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

BENEFITS FOR THE TREATMENT OF LYMPHEDEMA

Benefits will be paid the same as any other Sickness for the diagnosis, evaluation, and treatment of lymphedema including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a Physician.

Gradient Compression Garments:

1. require a prescription;
2. are custom-fit for the Insured Person; and
3. do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

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

BENEFITS FOR HEARING AIDS

Benefits will be paid for one hearing aid per hearing-impaired ear up to $2,500 per hearing aid every 36 months when Medically Necessary and ordered by a Physician or audiologist licensed in the state. Coverage includes:

(1) Initial hearing aids and replacement hearing aids not more frequently than every 36 months.

(2) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Insured Person.

(3) Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

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

PART IX
EXCLUSIONS AND LIMITATIONS

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

1. Acne;

2. Acupuncture;

3. Allergy including allergy testing; except as specifically provided in the policy;

4. Addiction, such as: nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;

5. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation;

6. Biofeedback;

7. Circumcision;

8. Congenital conditions, except as specifically provided for Newborn Infant or Adopted or Foster Child;

9. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for a Newborn Infant or Adopted or Foster Child removal of warts, non-malignant moles and lesions;

10. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;

11. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

12. Elective Surgery or Elective Treatment;

13. Elective abortion;

14. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;

15. Flat foot conditions; supportive devices for the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);

16. Health spa or similar facilities; strengthening programs;

17. Hearing examinations, except as specifically provided in the Benefits for Newborn Hearing Screening; hearing aids, except as specifically provided in the Benefits for Hearing Aids; cochlear implants or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

18. Hirsutism; alopecia;

19. Hypnosis;

20. 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;

21. Injury caused by, contributed to, or resulting from the use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;

22. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency when traveling for academic study abroad programs, business or pleasure;

23. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.;

24. Injury sustained while (a) participating in any intercollegiate or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

25. Investigational services;

26. Lipectomy;

27. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;

28. Voluntary participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

29. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy, provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;

30. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
    b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association's Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacist's American Hospital Formulary Service Drug Information (AHFS-DI);
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness;anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones, except for a Newborn Infant, Adopted or Foster Child who requires growth hormones for the treatment of a congenital condition; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

31. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

32. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study;

33. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;

34. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;

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

36. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;

37. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

38. Sleep disorders;

39. Speech therapy; naturopathic services;

40. Suicide or attempted suicide while sane or insane (including intentional drug overdose); or intentionally self-inflicted Injury;

41. Supplies, except as specifically provided in the policy;

42. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;

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

44. 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); and

45. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the "Medical Expense Benefits" (and under Major Medical, if coverage is afforded under Major Medical) provision.

For Loss of:

Life	$5,000
Two or More Members	$5,000
One Member	$2,500

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

The Accidental Death benefit is payable for the involuntary inhalation of gas and fumes and the involuntary taking of poison.

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

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

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.

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

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Network Pharmacy Prescription Drug Benefits

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

Copayment and/or Coinsurance Amount

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

- The applicable copayment and/or coinsurance; or
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.

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 Schedule of Benefits. For a single copayment and/or coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

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

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

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.firststudent.com or by calling *Customer Service* at 1-877-417-7345.

You cannot refill a prescription until 75% of the applicable supply limit has been used, except under certain circumstances during a state of emergency or disaster.

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. The Insured will pay the copayment and/or coinsurance applicable for the tier to which the Prescription Drug is assigned.

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 our designee. The reason for notifying the Company is to determine whether the Prescription Drug Product, in accordance with our 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. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.firststudent.com or by calling *Customer Service* at 1-877-417-7345.

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 Cost, 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.firststudent.com through the Internet or call *Customer Service* at 1-877-417-7345 for the most up-to-date tier status.

Rebates and Other Payments

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

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

Definitions

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

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

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

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

If the Insured has a life-threatening Injury or Sickness (one which is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Unproven Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

Network Pharmacy means a pharmacy that has:

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

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

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.firststudent.com or call *Customer Service* at 1-877-417-7345.

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

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

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

Additional Exclusions

In addition to the policy Exclusions and Limitations, 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. 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.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
4. 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.
5. 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.

RESOLUTION OF GRIEVANCE NOTICE
INTERNAL APPEAL PROCESS AND EXTERNAL INDEPENDENT REVIEW PROCESS
RELATED TO HEALTH CARE SERVICES

DEFINITIONS

For the purpose of this Notice, 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.

Grievance means a written complaint submitted by or on behalf of an Insured Person regarding:

1. The Company's decisions, policies, or actions related to availability, delivery or quality of health care services;
2. Claims payment, handling or reimbursement for health care services;
3. The contractual relationship between an Insured Person and the Company; or
4. The outcome of an Adverse Determination as defined.

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.

INFORMAL REVIEW

An Insured Person may submit a Grievance to the Company for informal review after an event that causes a dispute.

1) If the Grievance concerns a clinical issue and the informal consideration decision is not in favor of the Insured, the Company shall on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner, provide the Insured with information on how to submit written material for an Internal Appeal.
2) If the Grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the Insured, the Company shall issue a written decision that includes the availability of the Commissioner's office and the Managed Care Assistance Program for assistance, including the telephone number and address of the office of both.
3) If the Company is unable to render an informal consideration decision within 10 business days after receipt of the Grievance, the Company on the day the Company determines an informal consideration decision cannot be made before the tenth business day after receipt of the Grievance, the Company will provide the Insured with information on how to submit written material for an Internal Appeal.

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;
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 received, 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; and
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
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 (EIR) of an Adverse Determination

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.

EXTERNAL INDEPENDENT REVIEW

An Insured Person or Authorized Representative may submit a request for an External Independent Review when the service 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 Procedure 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 120 days to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Commissioner. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

I. Standard External Review (SER) Process

1. Within 10 business days after receiving the SER request notice, the Commissioner will notify the Company of the request for SER and request the Company deliver to the Commissioner any information needed to 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. The Commissioner shall notify the Company, 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 Commissioner's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Commissioner'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:
   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 150 days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

4. a. The Company shall, within 7 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 it 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.

II. Expedited External Review (EER) Process

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Commissioner at the time the Insured Person receives:
   a. An Adverse Determination if:
      (i) the Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      (ii) 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:
      (i) 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
      (ii) the Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

   An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.
2. Upon receipt of an EER request, the Commissioner shall, within 3 business days send a copy of the request to the Company and request the Company deliver to the Commissioner, no later than one business day after request, any information needed 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 sections II. 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 Commissioner shall notify the Company, 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 Commissioner's response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Commissioner'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 IRO from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
   a. The Company shall, within the same business day of receiving notice, 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 4 business days 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, within 1 business day, approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

III. Standard Experimental or Investigational Treatment External Review (SEIER) Process

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 Commissioner
2. Within 10 business days after receiving the SEIER request notice, the Commissioner will notify the Company of the request for SEIER and request the Company to deliver to the Commissioner any information needed to 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:
      (i) 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
      (ii) 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:
      (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
      (iii) 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:
      (i) 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
      (ii) 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. The Commissioner shall notify the Company, 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 Commissioner's response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Commissioner'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 SEIER, the Commissioner shall:
   a. Assign an IRO from the Commissioner's approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 150 days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
5. a. The Company shall, within 7 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 it decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
8. Within 45 days after receipt of the SEIER 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.
9. 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.

IV. Expedited Experimental or Investigational Treatment External Review (EEIER) Process

1. An Insured Person or an Authorized Representative may make a written or an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the Commissioner at the time the Insured Person receives:
   a. An Adverse Determination if:
      (i) The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      (ii) 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:
      (i) 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

(ii) 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 Commissioner shall, within 3 business days, send a copy of the request to the Company and request the Company deliver to the Commissioner, no later than one business day after request, any information needed to 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:
      (i) 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
      (ii) 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:
      (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
      (iii) 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:
      (i) 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
      (ii) 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 Section IV. 1. a. and b. above; and
   f. the Insured Person has provided all the information and forms necessary to process the request.
3. The Commissioner shall immediately notify the Company, 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 Commissioner's response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Commissioner'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. 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.
6. a. The Company shall, within the same business day of receiving request, provide the IRO with any documents and information the Company 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. 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.

7. 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.
8. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
    a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
    b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
    c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
9. The IRO shall make a decision and provide oral or written notice of its decision within 4 business days after receipt of the opinions from each clinical reviewer.
10. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall, within 1 business day, 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. An External Review decision is binding on the Insured Person except 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.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service for treatment, or 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 and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3) Bills should be received by the Company within 180 days of service or as soon as reasonably possible to be considered for payment. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:
UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:
FirstStudent
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-505-4160
or visit our website at www.firststudent.com

Marketed by:
Insurance for Students, Inc.
5295 Town Center Road, Suite 101
Boca Raton, Florida 33486
1-800-356-1235
www.insuranceforstudents.com

Online Access to Account Information

UnitedHealthcare StudentResources Insureds have online access to claims status, Explanation of Benefits, correspondence and coverage information via My Account at www.firststudent.com. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.firststudent.com. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from www.firststudent.com to access your account information.

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

This Brochure is based on Policy # 2012-201610-1 v3-NOC 1(12/12/12)

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2012-201610-1

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

NOC 1 (12/12/2012)

- Added to Exclusion for Pre-Existing Conditions – "provided the coverage was continuous to a date within 63 days prior to the Insured's effective date under this policy;"