

2012-2013

PLEASE NOTE:

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

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.

Notice Regarding Your Student Health Insurance Coverage

This 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. This 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 an Insured Person 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 an Insured Person is 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 this plan on a voluntary basis. Eligible dependents of enrolled students may purchase this plan on a voluntary basis.

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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.

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 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under 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.

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

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

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.

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.

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 intellectual disability 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.

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

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

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

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

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

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

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

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

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

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

NEWBORN INFANT AND ADOPTED CHILDREN means: 1) a newly born child of the Insured from the moment of birth provided that person is insured under this policy; 2) a child adopted by the Insured, regardless of the age at which the child was adopted, provided the person adopting the child is insured under this policy on the date the adoption becomes effective; and 3) a child who has been placed for adoption with the Insured and for whom the application and approved procedures for adoption have been completed provided the person adopting the child is insured under this policy on the date the child is placed with the Insured.

Such child will be covered under the policy for the first 31 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; or 3) the date of placement of the child for adoption. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

The term "child" for purposes of initial coverage of an adopted child or child placed for adoption but not for purpose of termination of coverage of such child, means a person under the age of (18) eighteen.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year 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: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which originates, is diagnosed, treated or recommended for treatment within the 12 months immediately prior to 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 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
PHOENIX SCHOOL OF LAW- STUDENT PLAN
2012-202477-1
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	80% except as noted below
Coinsurance Out-of-Network	60% 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. The 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 are subject to the policy Maximum Benefit unless otherwise specifically stated. 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		
Surgery:	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous:	Preferred Allowance	Usual and Customary Charges
<i>(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</i>		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	Preferred Allowance	Usual and Customary Charges

Outpatient

Physiotherapy:	Preferred Allowance	Usual and Customary Charges
<i>(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.)</i>		
Medical Emergency:	Preferred Allowance	80% of Usual and Customary Charges
	\$100 Copay per visit	\$100 Deductible per visit
<i>(\$100 Copay/ per visit Deductible is in addition to the Policy Deductible; waived if admitted to the Hospital.)</i>		
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)	No Benefits
	\$15 Copay per prescription for Tier 1	
	\$35 Copay per prescription for Tier 2	
	\$70 Copay per prescription for Tier 3	

Other

Ambulance:	Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
<i>(\$1,000 maximum (Per Policy Year)) (Durable Medical Equipment benefits payable under the \$1,000 maximum Per Policy Year are not included in the \$250,000 Maximum Benefit)</i>		
Consultant:	Preferred Allowance	Usual and Customary Charges
Dental:	80% of Usual and Customary Charges	80% of Usual and Customary Charges
<i>(\$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.)</i>		
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	\$2,500 - \$5,000 maximum
Home Health Care:	Preferred Allowance	Usual and Customary Charges
<i>(See Benefits for Home Health Services)</i>		
Preventive Care Services:	100% of Preferred Allowance	No Benefits
<i>(No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.)</i>		
Diabetes Services:	Paid as any other Sickness	Paid as any other Sickness
<i>(See also Benefits for Diabetes Equipment and Supplies)</i>		
Mental Illness Treatment:	Paid as any other Sickness	Paid as any other Sickness
Reconstructive Surgery	Paid as any other Sickness	Paid as any other Sickness
Following Mastectomy:		
<i>(See Benefits for Mastectomy and Reconstructive Surgery)</i>		
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: (X) *Coordination of Benefits (X) Excess Motor Vehicle Only () 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. Insured’s 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. Insured’s 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 Hospital expenses at a Preferred Hospital 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.

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.
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 Mastectomy and Reconstructive Surgery.
36. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. Benefits will be paid for Medically Necessary: 1) outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals; and 2) Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices. See also Benefits for Diabetes Equipment and Supplies.
37. **Home Health Care:** See Benefits for Home Health Services.
38. **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.
39. **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.
40. **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 OUTPATIENT SERVICES

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

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

BENEFITS FOR MASTECTOMY AND RECONSTRUCTIVE SURGERY

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

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

BENEFITS FOR BIRTH OF ADOPTED CHILD

Benefits will be paid the same as any other Sickness for the cost of the birth of any child legally adopted by the Insured if all the following are true:

- 1) The child is adopted within one year of the birth;
- 2) The Insured is legally obligated to pay the costs of birth;
- 3) All Pre-Existing Conditions and other limitations have been met by the Insured, and
- 4) The Insured has notified the Company of his acceptability to adopt children pursuant to A.R.S. section 8-105, within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

This coverage is excess to any other coverage the natural mother may have for maternity benefits. If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The Insured adopting parents shall notify the Company of the existence and extent of the other coverage.

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

BENEFITS FOR CANCER CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for the Insured's Costs that are directly associated with a cancer clinical trial. "Insured's Costs" means any fee or expense that is covered under the policy for service or treatment that would be required if the Insured was receiving usual and customary care.

Insured's Costs do not include any drug or device provided by phase I cancer clinical trial, any investigational drug or device, non-health services required for an Insured to receive treatment or intervention, managing the research of the clinical trial, expenses that would not be covered under the Insured's policy and treatment or services provided outside the state of Arizona.

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

BENEFITS FOR OFF-LABEL PRESCRIPTION DRUGS FOR THE TREATMENT OF CANCER

If benefits are provided for Prescription Drugs under this policy, then benefits will be provided for any drug prescribed to treat an Insured for cancer if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia or accepted medical literature as described below. The accepted standard medical reference compendia are:

- 1) The American Hospital Formulary Service Drug Information, a publication of the American Society of Health System Pharmacists;
- 2) The national comprehensive cancer network drugs and biologics compendium;
- 3) Thomson micromedex compendium drugdex;
- 4) Elsevier gold standard's clinical pharmacology compendium; and
- 5) Other authoritative compendia as identified by the secretary of the United States department of health and human services; and
- 6) Medical literature may be accepted, if all of the following apply:
 - a) At least two articles from major peer reviewed professional medical journals which have been recognized, based on scientific or medical criteria, the drugs safety and effectiveness for treatment of the indication for which the drug has been prescribed;
 - b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug was unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed; and
 - c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer-reviewed medical literature pursuant to Sec. 186(t)(2)(B) of the Social Security Act (42 United States Code, Sec. 1395x(t)(2)(B)).

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

BENEFITS FOR DIABETES EQUIPMENT AND SUPPLIES

Benefits will be paid for the Covered Medical Expenses incurred for diabetes equipment and supplies that are Medically Necessary and prescribed by a Physician. This benefit includes the following:

- 1) Blood glucose monitors, including those for the legally blind;
- 2) Test strips for glucose monitors and visual reading and urine testing strips;
- 3) Insulin preparation and glucagon;
- 4) Insulin cartridges;
- 5) Drawing up devices and monitors for the visually impaired;
- 6) Injection aids;
- 7) Insulin cartridges for the legally blind;
- 8) Syringes and lancets including automatic lancing devices;
- 9) Prescribed oral agents for controlling blood sugar;
- 10) Podiatric appliances for the prevention of complications associated with diabetes, to the extent coverage is required under Medicare; and
- 11) Any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999. The coverage required in this paragraph (11) is effective six months after the coverage is required under Medicare.

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

BENEFITS FOR HOME HEALTH SERVICES

Benefits will be paid for the Usual and Customary Charges for Home Health Services for any Injury or Sickness, as defined in the policy, provided that such treatment would be covered on an Inpatient basis and is provided by a licensed home health agency, which a Physician, whose services would be covered under the policy if the treatment were performed in a Hospital, has prescribed in lieu of Hospital services. Treatment of the Injury or Sickness must be a Medical Necessity and must be provided as an alternative to Inpatient treatment in a Hospital.

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

BENEFITS FOR MAMMOGRAPHY SCREENING

Benefits will be paid the same as any other Sickness for mammography screening performed on dedicated equipment for diagnostic purposes on referral by a patient's Physician:

- 1) A baseline mammogram for a woman from age thirty-five to thirty-nine.
- 2) A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's Physician.
- 3) A mammogram every year for a woman fifty years of age and over.

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

BENEFITS FOR MEDICAL FOODS

If benefits are provided for Prescription Drugs under this policy, then benefits will be provided for Medical Foods needed to treat Inherited Metabolic Disorders. Benefits for Metabolic Formula and Modified Low Protein Foods will be paid at a Coinsurance percentage of 50% and limited to a total of \$5,000 per Policy Year. Metabolic Foods eligible for coverage must be prescribed by or ordered under the supervision of a Physician.

"Medical foods" means modified low protein foods and metabolic formula.

"Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry; involve amino acid, carbohydrate or fat metabolism; and includes testing under the newborn screening program.

"Metabolic formula" means foods that are all of the following:

- 1) Formulated to be consumed or administered enterally under the supervision of a licensed Physician.
- 2) Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.
- 3) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.
- 4) Essential to the person's optimal growth, health and metabolic homeostasis.

"Modified low protein foods" means foods that are all of the following:

- 1) Formulated to be consumed or administered enterally under the supervision of a licensed Physician.
- 2) Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.
- 3) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation
- 4) Essential to a person's optimal growth, health and metabolic homeostasis.

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

BENEFITS FOR AMINO ACID BASED FORMULA

If benefits are provided for Prescription Drugs under this policy, then benefits will be paid under the Prescription Drug benefit as specified on the Schedule of Benefits for amino-acid formula for eosinophilic gastrointestinal disorders. Benefits for amino-acid based formula will be paid at a Coinsurance percentage of 75% and limited to a total of \$20,000 per Policy Year.

Amino -acid based formula for eosinophilic gastrointestinal disorder are subject to the following limitations:

- 1) The Insured has been diagnosed with an eosinophilic gastrointestinal disorder
- 2) The Insured is under the continuous supervision of a licensed Physician
- 3) There is a risk of intellectual or physical impairment without the use of the formula.

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

BENEFITS FOR OUTPATIENT CONTRACEPTIVE DRUGS AND DEVICES

If benefits are provided for Prescription Drugs under this policy, then benefits will be paid under the Prescription Drug benefit for any prescribed drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive. This shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods.

In addition, benefits will be paid the same as for any other Sickness for Outpatient Contraceptive Services. Outpatient Contraceptive Services means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of United States Food and Drug prescription contraceptive methods to prevent unintended pregnancies.

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

BENEFITS FOR AUTISM SPECTRUM DISORDER

Benefits will be paid the same as any other Sickness for the treatment of Autism Spectrum Disorder. For the purposes of this benefit, "treatment" includes diagnosis, assessment and services.

"Autism spectrum disorder" means one of the three following disorders as defined in the most recent edition of the diagnostic and statistical manual of mental disorders of the American Psychiatric Association: a) Autistic disorder, b) Asperger's syndrome, c) Pervasive developmental disorder.

Benefits will be paid the same as for any other Sickness for Behavioral Therapy Services for Autism Spectrum Disorder provided to an Insured Person up to the age of 16. Behavioral Therapy Services must be provided or supervised by a licensed or certified Physician.

"Behavioral Therapy Services" means interactive therapies derived from evidence based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

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

PART VII
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; caffeine addiction, non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
5. Milieu therapy, learning disabilities, behavioral problems, except for Medically Necessary Behavioral Therapy Services provided or supervised by a licensed or certified Physician as specifically provided for in the Benefits for Autism Spectrum Disorder, parent-child problems, conceptual handicap, developmental delay or disorder or intellectual disability;
6. Biofeedback;
7. Circumcision;
8. Congenital conditions, except as specifically provided for Newborn and Adopted Children;
9. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for Newborn and Adopted Children; 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; hearing aids; or 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; except as specifically provided in the policy;
21. Injury caused by, contributed to, or resulting from the addiction to or 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 for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
23. 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;
24. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
25. 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;
26. Investigational services;
27. Lipectomy;
28. 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;
29. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
30. 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;
31. 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 policy;
 - 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;
 - 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; or
 - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

32. 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;
33. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study; except as specifically provided in the policy;
34. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
35. 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;
36. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
37. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or except for treatment of chronic purulent sinusitis;
38. 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;
39. Sleep disorders;
40. Speech therapy; naturopathic services;
41. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
42. Supplies, except as specifically provided in the policy;
43. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
44. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
45. 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
46. 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:

COORDINATION OF BENEFITS PROVISION

Definitions

- (1) **Allowable Expenses:** Any health care expense, including Coinsurance, or Copayments and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.
- (a) The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.
 - (b) For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.
 - (c) For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
 - (d) If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admission, and preferred provider arrangements.

- (2) **Plan:** A form of coverage with which coordination is allowed.

Plan includes all of the following:

- (a) Group insurance contracts and subscriber contracts.
- (b) Uninsured arrangements of group or group-type coverage.
- (c) Group coverage through closed panel plans.
- (d) Group-type contracts, including blanket contracts.
- (e) The medical care components of long-term care contracts, such as skilled nursing care.
- (f) The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
- (g) Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

Plan does not include any of the following:

- (a) Hospital indemnity coverage benefits or other fixed indemnity coverage.
 - (b) Accident only coverage.
 - (c) Limited benefit health coverage as defined by state law.
 - (d) Specified disease or specified accident coverage.
 - (e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
 - (f) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
 - (g) Medicare supplement policies.
 - (h) State Plans under Medicaid.
 - (i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
 - (j) An Individual Health Insurance Contract.
- (3) **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a primary plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.
- (4) **Secondary Plan:** A Plan that is not the Primary Plan.
- (5) **We, Us or Our:** The Company named in the policy to which this endorsement is attached.

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

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

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

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

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

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

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

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

- (2) Dependent Child/Parents Married or Living Together. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:

- (a) the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
- (b) However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

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

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

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

If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:

- (a) First, the Plan of the parent with custody of the child.
- (b) Then Plan of the spouse of the parent with the custody of the child.
- (c) The Plan of the parent not having custody of the child.
- (d) Finally, the Plan of the spouse of the parent not having custody of the child.

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

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

- (6) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

- (a) First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
- (b) Second, the benefits under the COBRA or continuation coverage.
- (c) If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

- (7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

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

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

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

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

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

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:

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.

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.

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* 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* 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.

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.

Claim Procedure

In the event of Injury or Sickness, students should:

- 1) Report 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# and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
- 3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. 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:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
800-505-4160
Claims@uhcsr.com
Customerservice@uhcsr.com

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

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 # 2012-202477-1

v5-NOC 1 (12/12/12)

POLICY NUMBER: 2012-202477-1

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;”