2016-2017

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for Students of

NOTRE DAME OF MARYLAND UNIVERSITY

Available through:

Institutions of Higher Education Consortium Trust (IHECT)

This Certificate is not a Medicare supplement Certificate. It is not designed to fill the 'gaps' of Medicare. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the Company.

UnitedHealthcare Insurance Company

Administered by
UnitedHealthcare StudentResources
P.O. Box 809025
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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-505-4160 or visiting us at www.firststudent.com.

Eligibility

All full-time NDMU undergraduate students (taking at least 12 credits per semester), graduate studies students (taking at least 9 credits per semester), School of Pharmacy students (taking at least 10 credits per semester), and international undergraduate students on a visa are automatically enrolled in the University insurance plan unless proof of comparable coverage is furnished.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse or Domestic Partner and dependent children including a grandchild, child placed with the Insured for legal adoption, child of a Domestic Partner, or a child for whom the Named Insured is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration and a child for whom the Named Insured is under a court order to provide coverage, 26 years of age. A dependent shall also mean a dependent of the Insured as the term is used in 26 U.S.C §§ 104, 105, 106, and any regulations adopted under those sections, under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2016. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. The policy includes a Grace Period provision. To avoid a lapse in coverage, your premium must be received within 30 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

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

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

Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits are payable before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the Insured remains Totally Disabled but not to exceed 12 months after the Termination Date. Proof of total disability may be required at any time.

If an Insured begins a course of Dental Treatment before the Termination Date and requires two or more visits on separate days to a dentist's office, Covered Medical Expenses for such course of treatment will continue to be paid but not to exceed 90 days after the Termination Date.

If an Insured is receiving orthodontic treatment for which benefits are payable before the Termination Date, Covered Medical Expenses for such orthodontic treatment will be covered in one of the following methods:

- For 60 days after the date coverage terminates when the orthodontic provider has agreed to or is receiving monthly payments.
- Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

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

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

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.

Preferred Provider Information

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

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-4160 and/or by asking the provider when making an appointment for services.

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

"Out-of-Network" providers have not agreed to any prearranged fee schedules. 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 Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-800-505-4160 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.

Out-of-Network Emergency Services

When Emergency Services for a Medical Emergency are provided by an out-of-network Provider, benefits will be subject to the same Copay or Coinsurance amounts that are applicable to Emergency Services provided by a Preferred Provider. Benefits for Emergency Services received from an out-of-network Provider will be paid at the greater of the following, excluding any Copays or Coinsurance that would have been imposed if the service had been received from a Preferred Provider: 1) the benefits specified in the Schedule of Benefits; 2) the Preferred Allowance negotiated with Preferred Providers (if there is more than one amount negotiated with Preferred Providers, the amount shall be the median of these negotiated amounts); 3) the amount payable calculated using the Company's Usual and Customary Charges; or 4) the amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service. Any other provisions of the policy that apply to cost-sharing for services received from an out-of-network Provider, such as the policy Deductible or Out-of-Pocket Maximum, will continue to apply to Emergency Services received from an out-of-network Provider.

Referral to Out-of-Network Specialist Physician and Non-Physician Specialist in Certain Circumstances

Referrals are not required to see out-of-network Providers; however in certain circumstances a referral may be requested. When an Insured Person is diagnosed with a condition or disease that requires specialized health care service or medical care; the Insured may request a referral to a specialist Physician or a non-Physician specialist who is not part of the Preferred Provider network if:

1. The Company does not have in its provider panel a specialist Physician or a non-Physician specialist with the professional training and expertise to treat or provide health care services for the Sickness or Injury; or
2. The Company cannot provide reasonable access to a specialist Physician or a non-Physician specialist with the professional training and expertise to treat or provide health care services for the Sickness or Injury without unreasonable delay or travel.

Benefits in these two situations will be paid at the level of benefits shown as Preferred Provider benefits.

Payment to Out-of-Network On-Call Physicians or Hospital – Based Physicians

If an out-of-network on-call Physician or Hospital-based Physician has obtained and accepted an assignment of benefits from an Insured and notified the Company of the assignment in the manner prescribed by the Commissioner of Insurance, the on-call Physician or Hospital-based Physician may not: 1) collect from the Insured any money owed to the on-call Physician or Hospital-based Physician by the Company for covered services rendered to the Insured by the on-call Physician or Hospital-based Physician; or 2) maintain any action against the Insured to collect or attempt to collect any money owed by the Company for covered services rendered to the Insured by the on-call Physician or Hospital-based Physician. The Insured shall only be liable to the on-call Physician or Hospital-based Physician for any Deductible, Copayment, or Coinsurance amount owed by the Insured for covered services rendered to the Insured by the on-call Physician or Hospital-based Physician and payment or charges for services that are not covered services under the policy. If Medicare is the primary insurer and the Company is the secondary insurer, the on-call Physician or Hospital-based Physician may collect from the Insured any amount up to the Medicare approved or limiting amount, as specified under the federal Social Security Act, that is not owed to the on-call Physician or Hospital-based Physician by Medicare or the Company after coordination of benefits has been completed.

The Company will pay the on-call Physician or Hospital-based Physician for covered services rendered to an Insured when an assignment of benefits has been obtained and accepted and the Company has been notified as required: 1) within 30 days after receipt of a claim; and 2) in accordance with the reimbursement rates as required by Maryland Insurance Law. The Company may seek reimbursement from an Insured for any payment for a claim or portion of a claim submitted by an on-call Physician or Hospital-based Physician and paid by the Company that the Company determines is the responsibility of the Insured based on the policy provisions.

Payment to Out-of-Network Physicians Not On-Call or Hospital-Based

The Company will not: 1) prohibit the assignment of benefits to a Physician by an Insured; or 2) refuse to directly reimburse an out-of-network Physician under an assignment of benefits.

The Company may refuse to directly reimburse an out-of-network provider under an assignment of benefits if: 1) the Company receives notice of the assignment of benefits after the time the Company has paid the benefits to the Insured; 2) the Company, due to inadvertent administrative errors, has previously paid the Insured; 3) the Insured withdraws the assignment of benefits before the Company has paid the benefits to the out-of-network provider; or 4) the Insured paid the out-of-network provider the full amount due at the time of service.

Continuity of Care

At the request of the Insured Person or their parent, guardian, designee or health care provider, the Company will allow a new enrollee in the plan to continue to receive Covered Medical Expenses rendered by an out-of-network Provider at the time of the Insured Persons transition to coverage under the policy from another carrier's policy for the conditions listed below:

1. Acute conditions, which are medical or dental conditions that involve a sudden onset of symptoms due to an Injury, Sickness, or any other medical or dental problem that requires prompt medical attention and has a limited duration.
2. A serious chronic condition, which is a medical or dental condition due to a disease, a Sickness, or any other medical or dental problem that is serious in nature, persists without full cure or worsens over an extended period of time, and is actively managed or supervised by a Physician to maintain remission or prevent deterioration.
3. Pregnancy.
4. Mental Illness and Substance Use Disorders.
5. Any other condition where the out-of-network Provider and the Company reach agreement on continuity of care.

Examples of the conditions listed above include:

1. Bone fractures.
2. Joint replacements.
3. Heart attacks.
4. Cancer.
5. HIV/AIDS.
6. Organ transplants.

The Company will pay the out-of-network Provider the rate and method of payment the Company would normally pay and use for Preferred Providers who provide similar services in the same or similar geographic area.

The out-of-network Provider may decline to accept the rate or method of payment by giving 10 days' prior notice to the Insured and Company. If the out-of-network Provider does not accept the rate or method of payment, the out-of-network Provider and the Company may reach agreement on an alternative rate or method of payment for the Covered Medical Expenses. The rates and methods of payment shall:

1. Be subject to any state or federal requirements applicable to reimbursement for health care providers.
2. Ensure that the Insured is not subject to balance billing and the Copayment, Deductibles and Coinsurance required for the services rendered are the same as those that would be required if the Insured were receiving the services from a Preferred Provider.

If the out-of-network Provider does not accept the rate and method of compensations specified above the following applies:

1. The out-of-network Provider is not required to continue to provide the services.
2. The Insured may assign benefits to the out-of-network Provider and the provider may balance bill the Insured to the extent as if this provision did not exist.
3. Unless the Insured has assigned benefits to the out-of-network Provider, the Company shall facilitate transition of the Insured to a Preferred Provider.

At the request of the Insured Person, or the Insured Person's parent, guardian, designee, or health care provider; the Company will accept a preauthorization from a relinquishing carrier for procedures, treatments, medications, or services covered under the benefits offered by the Company, within the following time periods:

1. The lesser of the course of treatment or 90 days; and
2. The duration of the three trimesters of a pregnancy and the initial postpartum visit.

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

NETWORK PHARMACY PRESCRIPTION DRUG BENEFITS

Network Pharmacy benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the UHCP PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

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

PRESCRIPTION DRUGS FROM A RETAIL OR MAIL-ORDER PHARMACY

$20 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply

$40 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply

$65 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply

When a Prescription Drug is classified as a Maintenance Medication according to Maryland law and as written by the Physician:

- Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug; and
- Thereafter, up to a consecutive 90-day supply of a Prescription Drug subject to a Copay per prescription at 2.5 times the Copay for a 31 day supply.

COPAYMENT AMOUNT

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

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

For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment; or
- The Prescription Drug Cost for that Prescription Drug Product.

The applicable Copay will never be greater than the retail cost of the Prescription Drug.

Additional Exclusions:

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental Services and medications used for Experimental Services, except as specifically provided in the policy for Approved Clinical Trials.
4. 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.

5. 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. Please access www.uhcsr.com through the Internet or call Customer Service at the telephone number on your ID card for information on which over-the-counter drugs are excluded.
   Note: Notwithstanding this exclusion, we will provide immediate coverage for excluded Prescription Drug Products described above if, in the judgment of the authorized Prescriber; a) The over–the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or b) An equivalent over-the-counter drug: i) has been ineffective in treating the Insured's disease or condition; or ii) has caused or is likely to cause an adverse reaction or other harm to the Insured.
6. Outpatient orthomolecular therapy, including nutrients, vitamins, and food supplements.
7. Prescription Drug Products not included on Tier–1, 2, or 3 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.
   Note: We will provide immediate coverage for a Prescription Drug Product if, in the judgment of the Authorized Prescriber:
   - The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
   - The covered Prescription Drug Product on the Prescription Drug List:
   - Has been ineffective in treating the Insured Person's disease or condition; or
   - Has caused or is likely to cause an adverse reaction or other harm to the Insured person.
8. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Please access www.uhcsr.com through the Internet or call Customer Service at the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.
   Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:
   - The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
   - The covered Prescription Drug Product on the Prescription Drug List:
   - Has been ineffective in treating the Insured Person's disease or conditions; or
   - Has caused or is likely to cause an adverse reaction or other harm to the Insured Person.
9. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Please access www.uhcsr.com through the Internet or call Customer Service at the telephone number on your ID card for information on which Prescription Drug Products classified as Therapeutic Equivalent.
   Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgment of the Authorized Prescriber:
   - The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
   - The covered Prescription Drug Product on the Prescription Drug List:
   - Has been ineffective in treating the Insured Person's disease or conditions; or
   - Has caused or is likely to cause an adverse reaction or other harm to the Insured Person.

Definitions:

Authorized Prescriber has the meaning stated in Section 12-101 of the Health Occupations Article of the Maryland Code.

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

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

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

Experimental services means medical, dental, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental services do not include Approved Clinical Trials as specifically provided for in the policy.

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.

Maintenance Medication means a Prescription Drug anticipated to be used for six months or more to treat a chronic condition. Contact the Company to obtain a copy of the list of Maintenance Medications.

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.

Out-of-Network Pharmacy means a pharmacy that has not 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.uhcsr.com or call Customer Service at 1-855-828-7716.

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

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

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

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

Specialty Prescription Drugs – if you require Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Pharmacy, your benefits will be provided under the Out-of-Network Prescription Drug Benefit.

Designated Pharmacies – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Pharmacy, your benefits provided under the Out-of-Network Prescription Drug Benefit.

Please present your ID card to the Network Pharmacy when the prescription is filled. If you do not present the card, the pharmacy may require you to pay for the Prescription Drug Product at the time it is dispensed. In that case you should submit a reimbursement form for prescriptions filled at a Network Pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or Network Pharmacies, please visit www.uhcsr.com and log in to your online account or call 1-855-828-7716.

If you do not use a Network Pharmacy, you will be responsible for the out-of-network Deductible or Coinsurance for the prescription.

Insured Person's Right to Request an Exclusion Exception for UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-800-505-4160. The Company will notify the Insured Person of the Company's determination within 72 hours.

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

External Review
If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-800-505-4160. The Independent Review Organization (IRO) will notify the Insured Person of the determination within 72 hours.

Expedited External Review
If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-800-505-4160 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

OUT-OF-NETWORK PRESCRIPTION DRUG BENEFITS

Benefits are available at an Out-of-Network Pharmacy for Prescription Drugs as specified in the Schedule of Benefits subject to all terms of the policy and as specified below.

Deductible and/or Coinsurance Amount
For Prescription Drugs at an out-of-network retail pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Deductible and/or Coinsurance; or
- The Prescription Drug retail cost for that Prescription Drug.

For Prescription Drug Products from an out-of-network mail order pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Deductible and/or Coinsurance; or
- The Prescription Drug Cost for that Prescription Drug Product.

The applicable Deductible and/or Coinsurance will never be greater than the retail or mail order cost of the Prescription Drug.

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 per prescription Deductible, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a Prescription Drug Product is classified as a Maintenance Medication according to Maryland law and as written by the Physician, the following supply limits apply:

- Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug Product; and
- Thereafter, up to a consecutive 90 day supply of a Prescription Drug Product subject to a Copayment up to 2.5 times the Deductible for a 31-day supply.

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

When prescriptions are filled at pharmacies outside the network, the pharmacy may require you to pay for the prescriptions out-of-pocket. You should submit the receipts for reimbursement to UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at Out-of-Network Pharmacies.

Medical Expense Benefits – Injury and Sickness

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

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

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

Inpatient

1. **Room and Board Expense.**
   The rate approved by the Health Services Cost Review Commission (HSCRC) for facilities in the state of Maryland. For all other areas, daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

2. **Intensive Care.**
   See Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**
   When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.

- Blood products, both derivatives and components such as biologics, serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**
   See Benefits for Maternity Expenses.

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

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

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

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

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

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

10. **Pre-admission Testing.**
    Benefits include and are payable for routine tests such as:
    - Complete blood count.
    - Urinalysis.
    - Chest X-rays.

    Major diagnostic procedures such as those listed below will be paid under the "Hospital Miscellaneous" benefit:
    - CT scans.
    - NMR's.
    - Blood chemistries.

Outpatient

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

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

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

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

15. **Physician's Visits (Outpatient).**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery, Habilitative Services, or Rehabilitative Services.
Physician's Visits for preventive care are provided as specified under Preventive Care Services.

16. **Chiropractic Services (Outpatient).**
Services provided in a Chiropractor's office for the diagnosis and treatment of a Sickness or Injury.

17. **Habilitative Services (Outpatient).**
Includes but is not limited to the following Habilitative Services:
- Physical therapy.
- Occupational therapy.
- Speech therapy.

See also Benefits for Habilitative Services for Children.

18. **Rehabilitative Services (Outpatient).**
Includes but is not limited to the following Rehabilitative Services:
- Physical therapy.
- Occupational therapy.
- Speech therapy.

19. **Medical Emergency Expenses (Outpatient).**
Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.

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

20. **Diagnostic X-ray Services (Outpatient).**
See Schedule of Benefits. X-ray services for preventive care are provided as specified under Preventive Care Services.

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

22. **Laboratory Procedures (Outpatient).**
Laboratory Procedures including blood products, both derivatives and components such as biologics, serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

23. **Tests and Procedures (Outpatient).**
Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
- Physician's Visits.
- Habilitative Services.
- Rehabilitative Services.
- X-rays.
- Laboratory Procedures.

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

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

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

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

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

Benefits will be provided for prescribed orally administered cancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

Coverage for prescription eye drops will be provided in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services and when:

- The prescribing Physician indicates on the original prescription that additional quantities of the prescription eye drops are needed.
- The refill requested by the Insured Person does not exceed the number of additional quantities indicated on the original prescription by the prescribing Physician.
- The prescription eye drops prescribed by the Physician are a covered benefit under the policy.

Other

27. **Ambulance Services.**
To or from the nearest Hospital where needed medical services can appropriately be provided.

28. **Durable Medical Equipment.**
Durable Medical Equipment furnished by a supplier or home health agency that must be all of the following:

- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of disability, Injury or Sickness.
- Is appropriate for use in the home.

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

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part, including prosthetic devices such as leg, arm, back or neck braces, artificial legs, arms, or eyes and the training necessary to use these prostheses.
- Nebulizers and peak flow meters.
- Durable medical equipment or supplies associated or used in conjunction with medical foods and nutritional substance.

Dental braces are not durable medical equipment and are not covered.

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

30. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.
Pediatric dental benefits are provided in the Pediatric Dental Services provision.

Benefits will also be provided for anesthesia services and associated Hospital or ambulatory facility charges provided in conjunction with dental care for:

- An Insured child age 7 years or younger or an Insured who is developmentally disabled and cannot have successful dental treatment results under local anesthesia because of a physical, intellectual, or other medically compromising condition
- An Insured who is 17 years or younger who has dental needs of such magnitude that treatment should not be delayed or deferred and is extremely uncooperative, fearful, or uncommunicative. This includes Insureds whose lack of treatment can be expected to result in oral pain, infection, loss of teeth or other increased oral or dental morbidity.

31. **Mental Illness and Substance Use Disorder Treatment.**

Benefits will be provided for the following:

- Professional services by licensed professional mental health and substance use practitioners when acting within the scope of their license for the diagnosis and treatment of psychiatric conditions, mental illness or mental disorders, which include:
  - Diagnostic evaluation.
  - Crisis intervention and stabilization for acute episodes.
  - Medication evaluation and management (pharmacotherapy).
  - Treatment and counseling (including individual and group therapy visits).
  - Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling.
  - Professional charges for intensive outpatient treatment in a Physician's office or other professional setting.
  - Electroconvulsive therapy.
  - Inpatient professional fees.
  - Outpatient diagnostic tests provided and billed by a licensed, registered or certified mental health and substance use practitioner.
  - Outpatient diagnostic tests provided and billed by a laboratory, Hospital or other covered facility.
  - Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.
- Inpatient treatment in a Hospital or inpatient residential treatment center, which include facility services and supplies and the following room and board services.
  - Ward, semiprivate or intensive care accommodations. Private room accommodations are covered when determined by the treating Physician to be necessary. If a private room is determined to not be necessary by the treating Physician, the coverage will be limited to only the Hospital's average charge for semiprivate accommodations.
  - General nursing care.
  - Meals and special diets.
- Services such as partial hospitalization or intensive day treatment programs.
- Emergency room outpatient services and supplies billed by a Hospital for emergency room treatment.

Benefits for Mental Illness and Substance Use Disorder Treatment do not include:

- Services by pastoral or marital counselors.
- Therapy for sexual problems.
- Treatment for learning disabilities and intellectual disabilities.
- Telephone therapy.
- Travel time to the member's home to conduct therapy.
- Services rendered or billed by schools, or halfway houses or members of their staffs.
- Marriage counseling.

32. **Maternity.**

See Benefits for Maternity Expenses.

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:

- 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,* except that the current recommendation of the *United States Preventive Service Task Force* regarding breast cancer screening, mammography and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

35. **Reconstructive Breast Surgery Following Mastectomy.**
See Benefits for Reconstructive Breast Surgery Following a Mastectomy.

36. **Diabetes Services.**
Same as any other Sickness in connection with the treatment of diabetes.

Benefits will be paid for:
- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- 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.

37. **Home Health Care.**
Services received for continued care and treatment of an Insured Person in the home when:
- The institutionalization of the Insured Person in a Hospital or related institution or Skilled Nursing Facility would otherwise have been required if home health care were not provided.
- The plan or treatment providing the home health care service is established and approved in writing by the treating Physician.

Home Health Care benefits will be provided for Insureds who receive less than 48 hours of Inpatient hospitalization following a mastectomy or removal of a testicle or when the mastectomy or removal of a testicle is performed on an Outpatient basis. Benefits shall include one home visit schedule to occur within 24 hours after discharge from the Hospital or an outpatient health care facility following a mastectomy or removal of a testicle. An additional home visit will be provided if prescribed by the Insured's treating Physician.

38. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less and provided by a hospice care program.

Hospice care includes:
- Nursing Care provided by or under the supervision of a registered professional nurse.
- Physical or occupational therapy, or speech-language pathology services.
- Medical social services under the direction of a Physician.
- Services, including homemaker services, performed by a home health aide who has successfully completed a training program.
- Medical supplies (including drugs and biologics) and the use of medical supplies.
- Physician services.
- Short-term Inpatient care (including respite care and procedures necessary for pain control and acute and chronic symptom management) in an Inpatient facility meeting such conditions to be appropriate to provide such care. Respite care may only be provided on an intermittent, non-routine, and occasional basis and may not be provided consecutively over longer than five days.
- Counseling (including dietary counseling) with respect to care for the terminally ill Insured Person.
- Any other item or service which is recommended by the treating Physician.

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

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

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

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

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

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

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

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

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

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

- One or more of the following federally funded trials that meet required conditions:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency of Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A cooperative group center of any of the entities listed above or the Department of Defense, the Department of Veterans Affairs, or the Department of Energy.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

Benefits for transplants will be provided for non-experimental/investigational transplants. Transplants include autologous and nonautologuous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the policy. The cost of hotel lodging and air transportation are Covered Medical Expenses provided for the Insured recipient and a companion (or the Insured recipient and two companions if the recipient is under the age of 18 years), to and from the site of the transplant.

No benefits are payable for transplants involving permanent mechanical or animal organs.

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

44. **Cardiac Rehabilitation.**
Cardiac rehabilitation benefits for Insureds who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or who have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Benefits include the following:

- Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, Physician's revision of exercise prescription, and follow-up examination for Physician to adjust medication or change regimen.
- Outpatient rehabilitation services for physical therapy, speech therapy and occupational therapy.

Services must be provided at a place of service equipped and approved to provide cardiac rehabilitation. Benefits do not include maintenance programs, which consist of activities that preserve the Insured's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

45. **Family Planning.**
Benefits will be paid the same as any other Prescription Drug or device for any contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid the same as any other Sickness for the insertion or removal and any medical examination associated with the use of such contraceptive drug or device.

Family planning benefits also include services for voluntary sterilization.

46. **Hearing Aids.**
Hearing aids when required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are limited to one hearing aid per hearing impaired ear every 36 months.

47. **Infertility Services.**
Benefits will be paid the same as any other Sickness for the diagnoses and treatment of infertility. Benefits for infertility services include all outpatient services arising from in vitro fertilization procedures performed on an Insured Person.

Benefits for infertility services are payable if any of the following has occurred:

- The patient's oocytes are fertilized with the Insured's spouse's sperm, except when the patient's spouse is unable to produce and deliver functional sperm. The exception does not apply when the inability to produce and deliver functional sperm is a result from a vastectomy or any other method of voluntary sterilization.
- The patient and the patient's spouse have a history of infertility of at least 2 years duration, either through intercourse for a patient and spouse who are of the opposite sex or through six attempts of artificial insemination for a patient and spouse who are of the same sex.
- The infertility is associated with any of the following medical conditions:
    - Endometriosis.
    - Exposure in utero to diethylstilbestrol, commonly known as DES.
    - Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy).
    - Abnormal male factors, including oligospermia, contributing to the infertility.
- The Insured has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy.
- The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Benefits for infertility services provided to an Insured Person who is married to an individual of the same sex does not require:

- The Insured Person's spouse's sperm be used in the covered treatments or procedures.

- The Insured Person demonstrate infertility exclusively by means of a history of unsuccessful heterosexual intercourse.

The patient must either be the Named Insured or a covered Dependent of the Named Insured.

Benefits are not provided for a treatment or a procedure that would not treat a diagnosed medical condition of an Insured Person.

Benefits do not include:
- Ovum transplants.
- Gamete intrafallopian tube transfer.
- Zygote intrafallopian transfer.
- Cryogenic or other preservation techniques.
- Costs incurred for obtaining donor sperm

48. **Medical Foods.**
Benefits are payable for medical foods and nutritional therapy for the treatment of metabolic disorders when ordered and supervised by a Physician qualified to provide the diagnosis and treatment in the field of the disorder/disease.

49. **Nutritional Services.**
Benefits will be paid the same as any other Sickness for nutritional counseling provided by a licensed dietician-nutritionist, Physician, physician assistant or nurse practitioner for an Insured Person at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition. Benefits include medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a primary care Physician, to treat a chronic illness or condition.

50. **Patient Centered Medical Care Coordination.**
Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for costs associated with coordination of care for an Insured who has a chronic condition, serious illness, or complex health care needs, including:
- Liaison services between the Insured and Physicians, nurse coordinator, and the Care Coordination Team.
- Creation and supervision of the Care Plan, inclusive of an assessment of the Insured's medical needs.
- Education of the Insured and Insured's family regarding the Insured's disease, treatment compliance and self-care techniques.
- Assistance with coordination of care, including arrangement consultations with Specialist, and obtaining other supplies and services, including community resources.

"Care Coordination Team" means the Physicians and health care providers involved in the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet the Insured's health needs through communication and available resources to promote quality cost-effective outcomes.

51. **Pulmonary Rehabilitation.**
Benefits are provided to Insureds who have been diagnosed with significant pulmonary disease and are limited to one (1) program per lifetime. Benefits do not include maintenance programs, which consist of activities that preserve the Insured's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved or when no additional progress is apparent or expected to occur.

52. **Wellness Benefits.**
The Company will partially reimburse the Named Insured for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and/or programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. The Company will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).

In order to be eligible for reimbursement, the Insured must:
- Be an active member of the exercise facility; and

- Complete 50 visits in a six month period.

In order to obtain reimbursement, at the end of the six-month period, the Named Insured must submit:

- Documentation of the visits from the facility. Each time the Insured visits the exercise facility, a facility representative must sign and date the documentation of the visits.
- A copy of the Insured's current facility bill which shows the fee paid for their membership.
- A copy of the brochure that outlines the services the exercise facility offers.

Once the Company receives documentation of the visits and the bill, the Named Insured will be reimbursed the lesser of $200 or the actual cost of the membership per six-month period. Reimbursement will be issued only after the Insured has completed each six-month period even if 50 visits are completed sooner.

In the case where it is unreasonably difficult for the Named Insured to satisfy the requirements for reimbursement due to a medical condition or it is medically inadvisable for the Named Insured to attempt; the Company allows a reasonable alternative standard and any recommendations from the Named Insured's treating Physician will be accommodated. Contact the Company at 1-800-505-4160 for information on alternative standards. Alternative standards are determined on a case-by-case basis.

This Wellness Program benefit is available to the Named Insured only.

In addition, all Insureds have access to a voluntary online health risk assessment. The health risk assessment provides written feedback to each Insured who completes the assessment, with recommendations for lowering risks identified in the completed health risk assessment. Insureds may access the health risk assessment at www.firststudent.com.

53. **Wigs.**
Wigs and other scalp hair prosthesis as a result of hair loss due to chemotherapy or radiation treatment for cancer.

Mandated Benefits

BENEFITS FOR MATERNITY EXPENSES

Benefits will be paid for normal pregnancy and normal childbirth to the same extent as for any other Sickness subject to the following:

Benefits will be paid for a mother and newborn child for a minimum of:

1. 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery; and
2. 96 hours of inpatient hospitalization care after an uncomplicated cesarean section.

When the mother remains hospitalized for medical reasons beyond the minimum time specified above, newborn care will be provided for an additional 4 days of Hospital confinement.

If prescribed by the Physician, one Home Visit will be provided for a mother and her newborn child who remain in the Hospital for the above referenced lengths of time.

If the decision is made between the mother and the Physician for a shorter Hospital stay, then benefits will be provided for one Home Visit scheduled to occur within 24 hours after the Hospital discharge and one additional Home Visit if prescribed by the Physician.

"Home visit" shall:

1. be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;
2. be provided by a Registered Nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and
3. include any services required by the Physician.

With regard to this section only, Home Visits are not subject to any Copayment, Coinsurance or Deductible. Benefits will be provided even if the services do not occur within the time specified.

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING A MASTECTOMY

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for Reconstructive Breast Surgery and prosthesis for an Insured who has not had reconstruction surgery following a Mastectomy. Benefits shall include: 1) reconstruction of the breast on which the Mastectomy has been performed; 2) all stages of surgery and reconstruction of the nondiseased breast to establish symmetry; and 3) prosthesis and physical complications from all stages of the Mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Insured.

"Mastectomy" means the surgical removal of all or part of a breast.

"Reconstructive breast surgery" means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Benefits shall not be subject to benefit limitations for specific types of services. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

BENEFITS FOR MORBID OBESITY

Benefits will be paid the same as any other surgery for surgical treatment of Morbid Obesity that is recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with criteria approved by the National Institutes of Health.

"Body mass index" means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

"Morbid obesity" means a Body Mass Index that is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, diabetes, or any life-threatening or serious medical condition that is weight induced.

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

BENEFITS FOR HABILITATIVE SERVICES FOR CHILDREN

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for Habilitative Services for an Insured Person under the age of 19 years. Benefits will not be paid for Habilitative Services delivered through early intervention or school services.

"Habilitative services" within this benefit means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the child's ability to function.

"Congenital or genetic birth defect" within this benefit means a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defect includes, but is not limited to, autism or an autism spectrum disorder, cerebral palsy, intellectual disability, down syndrome, spina bifida, hydroencephalocele, and congenital or genetic developmental disabilities.

Benefits are included for Inpatient or outpatient Covered Medical Expenses arising from orthodontics; oral surgery; otologic; audiological and speech/language treatment involved in the management of birth defects known as cleft lip and cleft palate or both.

This benefit is not subject to any applicable limits specified in the policy schedule or benefits for physical therapy, speech therapy, occupational therapy or benefit limitations for specific types of services, but is subject to all Deductible, Copayments, Coinsurance, or any other provisions of the policy.

Coordination of Benefits Provision

Definitions

1. Allowable Expenses: Any health care expense, including Coinsurance, or Copays 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.

   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.

   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.

   For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.

   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. 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.
      a. Then Plan of the spouse of the parent with the custody of the child.
      b. The Plan of the parent not having custody of the child.
      c. 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. Dependent Child/Parental and Spousal Coverage. If a Dependent child has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a spouse's plan, the order of benefit determination shall be the same as provided under paragraph (8) for Longer/Shorter Length of Coverage.

   In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by the following:

      a. The benefits of the Plan of the parent/spouse whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent/spouse whose birthday falls later in that year.

b. However, if both the parents and spouse have the same birthday, the benefits of the Plan which covered the parent or spouse longer are determined before those of the Plan which covered the other parent/spouse for a shorter period of time.

6. 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.

7. 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.

8. 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.

   To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended. The start of the new plan does not include:

   a. A change in the amount or scope of a plan's benefits.
   b. A change in the entity that pays, provides, or administers the plan's benefits.
   c. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

   The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the persons coverage under the present plan has been in force.

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.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

For Loss Of

Life	$5,000
Two or More Members	$5,000
One Member	$2,500
Thumb or Index Finger	$1,250

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.

Extension of Benefits after Termination: The coverage provided under this benefit ceases on the Termination Date. However, if the loss results from an Injury that occurred while the Insured was covered under the policy, benefits will be paid for such loss provided the loss occurs within 90 days after the date of such Injury.

Loss scheduled in the Accidental Death and Dismemberment benefit and sustained in consequence of the Insured's being intoxicated or under the influence of any narcotic is excluded from coverage under this benefit.

Definitions

ADOPTED CHILD means the adopted child of an Insured while that Insured Person is covered under the policy. Such child will be covered from the moment of the earlier of either: 1) a judicial decree of adoption or 2) the assumption of custody, pending adoption, of a prospective adoptive child by a prospective adoptive parent for the first 31 days. The Insured must notify the Company, in writing, of the adopted child not more than 31 days after placement or adoption.

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

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

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

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

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at or from birth, including a hereditary defect. A congenital condition includes but is not limited to: 1) Autism or autism spectrum disorder; 2) cerebral palsy; 3) intellectual disability; 4) down syndrome; 5) spina bifida; 6) hydroencephalocele; and 7) congenital or genetic development disabilities.

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

COSMETIC means the use of a service or supply which is provided with the primary intent of improving appearance, not restoring bodily function or correcting deformity resulting from disease, trauma, or previous therapeutic intervention, as determined by a Physician.

COVERED MEDICAL EXPENSES means: 1) that portion of charges which are 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) that portion of charges which are 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 included in the Schedule of Benefits.

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

CUSTODIAL CARE means services that are any of the following:

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

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to the policy as a deductible, it shall mean the amount of Covered Medical Expenses that must be incurred by the Insured Person before becoming eligible for policy benefits. The deductible is subtracted from the amount or amounts otherwise payable as Covered Medical Expenses. The deductible will apply as specified in the Schedule of Benefits.

DEPENDENT means the legal spouse or Domestic Partner of the Named Insured and their dependent children including a grandchild, child placed with the Insured for legal adoption or child for whom the Named Insured is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration and a child for whom the Named Insured is under a court order to provide coverage. A dependent shall also mean a dependent of the Insured as the term is used in 26 U.S.C §§ 104, 105, 106, and any regulations adopted under those sections.

If the Named Insured is under a court order to provide coverage, the following apply:

1. The Insured will be allowed to include the child in the coverage regardless of any enrollment period restrictions;
2. If the eligible student is not currently enrolled, the Company shall enroll both the student and the child, without regard to enrollment period restrictions, within 20 business days after receipt of a medical support notice from the eligible student;
3. If the Insured has coverage but does not include the child in the enrollment then:
   a. The noninsuring parent, child support enforcement agency, or the Department of Health and Mental Hygiene may apply for coverage on behalf of the child; and
   b. The child may obtain coverage regardless of any enrollment period restrictions.
4. Coverage for the child may not be terminated unless the following written evidence is provided:
   a. The court order is no longer in effect;
   b. The child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
   c. The school has eliminated dependent coverage for all of its students; or
   d. The Insured is no longer a student.

If the child has coverage through an Insured parent, the Company will:

1. Provide membership cards or any other information necessary for the child to obtain benefits to the noninsuring parent; and
2. Process the claims and make appropriate payment to the noninsuring parent, health care provider, or Department of Health and Mental Hygiene if the noninsuring parent incurs expenses for health care provided to the child.

Children shall cease to be dependent at the end of the month in which they attain the age of 26 years. If the child is covered under the policy upon the attainment of the limiting age, such child shall remain a dependent under the policy at the option of the Named Insured until the policy Termination Date.

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-support because of mental or physical incapacity.
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 incapacitated as defined by subsections (1) and (2). The regular dependent premium will be charged to continue coverage for mentally or physically incapacitated dependent children.

DOMESTIC PARTNER means a person of the same or opposite sex who is neither married nor related by blood or marriage within four degrees of consanguinity to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence; and 3) contributes with the Named Insured for each other's welfare with the intention of remaining in the relationship indefinitely. Proof of a domestic partner relationship can be demonstrated by one of the following common primary financial interdependence documents:

1. Common Primary Residence Documents
   a. A joint deed or mortgage agreement of the primary residence.
   b. Lease agreement showing common interest in primary residence.
   c. Driver's license or State-issued identification listing a common address.
   d. Utility or other household bill with both the Named Insured and the name of the domestic partner.

2. Financial Interdependence Documents
   a. Designation of the domestic partner as primary beneficiary for life insurance or retirement benefits.
   b. Designation of the domestic partner as primary beneficiary in the other partner's will.
   c. Powers of attorney for property and/or health care.
   d. Mutual valid written advance directive approving the other domestic partner as health care agent.
   e. Joint ownership of either a bank account or credit account.
   f. Joint ownership or holding of investments.
   g. Joint ownership or lease of a motor vehicle.

EMERGENCY SERVICES means, with respect to a Medical Emergency:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C 1395dd(e)(3)).

EXPERIMENTAL SERVICE means medical, dental, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are not recognized as efficacious as

that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental services do not include Approved Clinical Trials as specifically provided for in the policy.

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

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

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

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of 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 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.

IMMEDIATE FAMILY means husband, wife, Domestic Partner, children, father, mother, brother, sister, and the corresponding in-laws.

INJURY means bodily injury which is all of the following:

1. directly and independently caused by an accident which is unrelated to any pathological, functional, or structural disorder.
2. a source of loss.
3. treated by a Physician within 30 days after the date of accident.
4. sustained while the Insured Person is covered under the policy.

All related conditions and recurrent symptoms of the same or similar condition will be considered one injury. Covered Medical Expenses incurred as a result of an injury that occurred prior to the policy's Effective Date will be considered a Sickness under the policy.

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

MAINTENANCE MEDICATION means a Prescription Drug anticipated to be used for six months or more to treat a chronic condition. Contact the Company to obtain a copy of the list of Maintenance Medications.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury, including the sudden and unexpected onset of a condition involving severe pain. 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.

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. All related conditions and recurrent symptoms of the same or a similar condition will be 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 means any child born of an Insured while that person is insured under the policy. Newborn Infants will be covered under the policy for the first 31 days after birth. 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.

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

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

OUTPATIENT means outpatient and out-of-hospital medical services.

PHYSICIAN means a health care provider, including a Community Health Resource, as defined in s. 19-2101 of the Health-General Article, who is: 1) duly licensed under the Maryland Health Occupations Article or in accordance with the licensing requirements of the state in which the Covered Medical Expense is incurred; and 2) acting within his/her lawful scope of practice; and 3) not a member of the Insured Person’s immediate family. Physicians who make referrals prohibited by §1-302 of Health Occupations Article will not be eligible for reimbursement.

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

PRESCRIPTION DRUGS 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.

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

REHABILITATIVE SERVICES means short-term outpatient rehabilitation therapies administered by a Physician.

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

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

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

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. All related conditions and recurrent symptoms of the same or a similar condition will be considered one Sickness.

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

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

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a 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. If the policy includes Preferred Provider benefits, the usual and customary charge for services provided by an out-of-network provider will not be less than the Preferred Allowance for a similarly licensed Preferred Provider for the same service in the same geographic region. No payment will be made under the policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

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. Sexual dysfunction not related to organic disease.

2. Cosmetic procedures, surgery, or related services to improve appearance.

   This exclusion does not apply to reconstructive procedures to restore bodily function or correct deformity resulting from disease, trauma or congenital or developmental anomalies for which benefits are otherwise payable under the policy, as determined by the treating Physician.

3. Personal care services and domiciliary care services.

4. Dental treatment which includes Hospital or professional care in connection with:
   - The operation or treatment for the fitting or wearing of dentures.
   - Orthodontic care or malocclusion.
   - Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of Injury to natural teeth due to an accident if the treatment is received within 6 months of the accident.
   - Dental implants.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services and benefits specified under Dental Treatment in the policy.

5. Experimental Services.

6. Foot care for the following:
   - Supportive devices for the foot including arch supports, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting.
   - Routine foot care including the care, cutting and removal of corns, calluses, and toenails.

   This exclusion does not apply to preventive foot care for Insured Persons with diabetes or treatment of a covered Injury or Sickness, as determined necessary by the treating Physician.

7. Lifestyle improvements, including nutritional counseling, or physical fitness programs, except as specifically provided under the policy.

8. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers. This exclusion does not apply to:
   - Treatment for hearing defects or hearing loss as a result of an infection or Injury. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
   - Hearing aids as specifically provided in the policy.

9. Immunizations related to foreign travel.

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

11. Services resulting from accidental bodily Injury arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

12. Reproductive services as follows, except as specifically provided in Infertility Services:
    - Ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.
    - Services to reverse a voluntary sterilization procedure.
    - Services for sterilization or reverse sterilization for a Dependent minor, except for FDA approved sterilization procedures for women with reproductive capacity.

13. The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of an Injury or Sickness.

    This exclusion does not apply to benefits specifically provided in Pediatric Vision Services.

14. Services performed or prescribed under the direction of a person who is not a Physician or performed beyond the scope of the practice of the Physician.

15. Services for which the Insured Person is not legally, or as a customary practice, required to pay in the absence of an Insurance policy.

16. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except surgery to treat joint abnormalities due to Injury and Sickness and where clear demonstrable radiographic evidence of joint abnormality exists.

17. Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the Insured is liable.

18. Medical or surgical treatment or regimen for reducing or controlling weight.

    This exclusion does not apply to:

    - Benefits specifically provided in Benefits for Morbid Obesity
    - Benefits specifically provided in Nutritional Services.

UnitedHealthcare Global: Global Emergency Services

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

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

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

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

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine

- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment (when included with your enrollment in an UnitedHealthcare **Student**Resources health insurance policy)
- Facilitation of Hospital Admission Payments (When Global Emergency Services is purchased as stand-alone supplement)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit www.firststudent.com for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

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

Services are also accessible via e-mail at Assistance@uhcglobal.com.

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

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

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

Online Access to Account Information

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

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

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

ID Cards

One way we are becoming greener is to no longer automatically mail out ***ID Cards***. Instead, we will send an email notification when the digital ID card is available to be downloaded from ***My Account***. An Insured student may also use ***My Account*** to request delivery of a permanent ID card through the mail.

General Provisions

CLAIM FORMS: Claim forms are not required.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company. Failure to provide notice of claim within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish notice of claim within the time required and that notice of claim was submitted as soon as was reasonably possible.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 180 days after the date of such loss. Written proof of loss submitted by a provider must be furnished to the Company within 180 days from the date a covered service is rendered. 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 within the time required and that proof of loss was submitted as soon as was reasonably possible.. 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.

PAYMENT OF CLAIMS: All indemnities provided by the policy will be payable to the Named Insured, and unless the Named Insured requests in writing not later than the time of filing proofs of such loss that payment be made directly to the Hospital or person rendering such service. Any accrued indemnities unpaid at the Named Insured's death may, at the option of the Company, be paid to the estate of the Named Insured or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay up to an amount not exceeding $5,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

Payment will not be made on claims, bills, or other demand for request for payment for health care services provided resulting from a health care provider's prohibited referral of an Insured, as determined by the appropriate regulatory board, to a health care entity: (1) in which the health care provider or the provider in combination with the health care provider's immediate family owns a beneficial interest; (2) in which the health care provider's immediate family owns a benefit interest of 3 percent or greater; or (3) with which the health care provider, the health care provider's immediate family, or the health care provider in combination with the health care provider's immediate family has a compensation arrangement.

Claims will be processed and payment will be made to the non-insuring parent, health care provider or Department of Health and Mental Hygiene for Covered Medical Expenses under the policy for an Insured Person if the non-insuring parent incurs charges for Covered Medical Expenses when the Company has been notified that the Insured parent is under a medical support court order. Please see the definition of Dependent for additional details.

TIME OF PAYMENT OF CLAIM: Indemnities payable under the policy for any loss will be paid within 30 days upon receipt of due written proof of such loss.

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

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

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

3. Submit claims for payment within 90 days after the date of service. Failure to furnish bills within the time required will not invalidate or reduce any claim if it was not reasonably possible to furnish the proof of loss within the time required and that proof of loss was submitted as soon as reasonably possible. If the Insured doesn't provide this information within one year and 90 days of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

FirstStudent
P.O. Box 809025
Dallas, Texas 75380-9025

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

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

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

Covered Dental Services

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

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

Pre-Treatment Estimate

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

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

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

Section 2: Benefits for Pediatric Dental Services

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

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

Dental Services Deductible

Benefits for pediatric Dental Services are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is $500 per Insured Person.

Any amount the Insured Person pays in Deductibles for Dental Care Services applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.

Out-of-Pocket Maximum

Any amount the Insured Person pays in Coinsurance for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.

Benefits

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

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	50%	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 set per 36 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam) Periodic Oral Evaluation provided in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry.	50%	50%
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 1 every 120 days.	50%	50%
Fluoride Treatments Topical fluoride varnish is limited to 8 units per 12 months for ages 0 to 2 years, 4 units per 12 months for ages over 3 years, and 4 units per 12 months per provider or location. Topical application of fluoride is limited to 1 treatment per 120 days. Treatment should be done in conjunction with dental prophylaxis.	50%	50%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	50%	50%
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	50%	50%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50%	50%
Endodontics (Root Canal Therapy)	50%	50%
Periodontal Surgery (Gum Surgery)	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period.	50%	50%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%
Adjunctive Services		
General Services (including Dental Emergency Treatment) Covered as a separate benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guards limited to 1 guard every 12 months.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Major Restorative Services		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 36 months. Pre-fabricated stainless steel permanent tooth crown is limited to 1 time per tooth per 36 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 6 months after the initial insertion. Limited to 1 per 6 months.	50%	50%
Pulpal Regeneration (Initial visit, interim medication replacement, and completion of treatment)	50%	50%
Overdenture (complete maxillary, partial maxillary, complete mandibular, partial mandibular)	50%	50%
Adjustment, maintenance and cleaning of maxillofacial prosthesis (extra or intraoral).	50%	50%
Recement of fixed partial denture.	50%	50%
Maxillofacial surgery.	50%	50%
Implants		
Implant Placement Limited to 1 time per 60 months.	50%	50%
Implant Supported Prosthetics Limited to 1 time per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	50%	50%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	50%	50%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
ORTHODONTICS		
Benefits for comprehensive orthodontic treatment, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.		
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is related to any of the identifiable syndromes listed above.	50%	50%

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
2. Procedures that are considered to be Experimental Services, except as specifically provided in the policy for Approved Clinical Trials.
3. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
4. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
5. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates, except as specifically provided in Section 6. Extension of Benefits after Termination.
6. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
7. Foreign Services are not covered unless required for a Dental Emergency.

Section 4: Claims for Pediatric Dental Services

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

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

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

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.

- The date the dental disease began.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage the Insured Person must include the name of the other carrier(s).

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

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

Submit claims for payment within 90 days after the date of service. Failure to furnish bills within the time required will not invalidate or reduce any claim if it was not reasonably possible to furnish the proof of loss within the time required and that proof of loss was submitted as soon as reasonably possible. If the Insured doesn't provide this information within one year and 90 days of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

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

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

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

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

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

Experimental Services - medical, dental, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental services do not include Approved Clinical Trials as specifically provided for in the policy.

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

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

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

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

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

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

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

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

Section 6: Extension of Benefits After Termination

If an Insured begins a course of dental treatment, except orthodontic treatment, before the Termination Date and requires two or more visits on separate days to a dentist's office, Covered Medical Expenses for such course of treatment will continue to be paid but not to exceed 90 days after the Termination Date.

If an Insured is receiving orthodontic treatment before the Termination Date, Covered Medical Expenses for such orthodontic treatment will be covered in one of the following methods:

- For 60 days after the date coverage terminates when the orthodontic provider has agreed to or is receiving monthly payments.
- Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

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

Non-Network Benefits
Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge. However, fees from a non-Network provider will never be less than the negotiated contract fee for that same Vision Care Service if that Vision Care Service had been received from a Network provider in the same geographic area.

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

Benefit Description
When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.
Benefits do not include applicable sales tax charged on Vision Care Services.

Benefits for medical or surgical treatment for eye disease which requires the services of a Physician are not covered under the Pediatric Vision Care Services but under the policy plan benefits.

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

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including but not limited to:

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

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

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

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

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

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

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

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

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

Low Vision

Benefits are available to an Insured Person who has severe visual problems that cannot be correct with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company.

This benefit includes:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.
- Prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	80% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	80% of the billed charge.
• Bifocal		100% after a Copayment of $40.	80% of the billed charge.
• Trifocal		100% after a Copayment of $40.	80% of the billed charge.
• Lenticular		100% after a Copayment of $40.	80% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Lens Extras	Once per year.		
• Polycarbonate Lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	80% of the billed charge.
• Eyeglass frames with a retail cost of $130-$160.		100% after a Copayment of $15.	80% of the billed charge.
• Eyeglass frames with a retail cost of $160-$200.		100% after a Copayment of $30.	80% of the billed charge.
• Eyeglass frames with a retail cost of $200-$250.		100% after a Copayment of $50.	80% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
• Covered Contact Lens Selection		100% after a Copayment of $40.	80% of the billed charge.
• Necessary Contact Lenses		100% after a Copayment of $40.	80% of the billed charge.
Low Vision Services Note that benefits for these services will be paid to the Insured Person. When obtaining these Vision Services, the Insured may be required to pay all billed charges at the time of service. The Insured may then obtain payment from the Company. Payment to the Insured will be limited to the amounts stated.	Comprehensive low vision examination once every 5 years, including 4 follow-up visits in any 5-year period		
• Low vision testing		100% of the billed charge.	80% of the billed charge.
• Low vision therapy		100% of the billed charge.	80% of the billed charge.
• Low vision optical devices		100% of the billed charge.	80% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

1. Non-prescription items (e.g. Plano lenses).
2. Replacement of lenses and/or frames that have been lost or stolen.
3. Optional Lens Extras not listed in Section 1: Benefits for Vision Care Services.
4. Missed appointment charges.
5. Services and materials resulting from the Insured Person's failure to comply with professionally prescribed treatment.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person may be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek payment from the Company.

Payment for Vision Care Services

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

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

Submit the above information to the Company:

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

Payment for Low Vision Services

To file a claim for reimbursement for Low Vision Services, the Insured Person must provide all of the following information at the address specified below:

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

Submit the above information to the Company:

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

By facsimile (fax):
248-733-6060

Submit claims for payment within 90 days after the date of service. Failure to furnish bills within the time required will not invalidate or reduce any claim if it was not reasonably possible to furnish the proof of loss within the time required and that proof of loss was submitted as soon as reasonably possible. If the Insured doesn't provide this information within one year and 90 days of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

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

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment. Non-Network benefits are covered as specified in the Schedule of Benefits.

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

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

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

Section 5: Extension of Benefits after Termination

Extension of Benefits after Termination: The coverage provided under this benefit ceases on the Termination Date. However, if the Insured has orders glasses or contact lenses before the Termination Date while the Insured was covered under the policy, benefits will be paid for the glasses or contact lenses provided the Insured receives the glasses or contact lenses within 30 days after the date of the order.

Notice of Complaint Process for Coverage Decisions

Right to Internal Appeal

Standard Internal Appeal

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 1-800-505-4160 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy.

Standard External Review

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

Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

Claims Appeals
UnitedHealthcare **Student**Resources
PO Box 809025
Dallas, TX 75380-9025
888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service at 1-800-505-4160 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Health Advocacy Unit of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(410) 528-1840 or 1-877-261-8807
www.oag.state.md.us/Consumer/HEAU.htm
heau@oag.state.md.us

Maryland Mental Health Parity and Addiction Equity Act Subscriber Notice

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) COMPLIANCE
For full mental health benefit information please refer to the Schedule of Benefits in this certificate, or contact UnitedHealthcare at the number on the back of your health plan ID card. In addition, you may refer to the Maryland Insurance Administration website: http//www.insurance.maryland.gov.

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
FirstStudent
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-505-4160
or visit our website at www.firststudent.com

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

This Certificate is based on Policy # 2016-202970-67.

Schedule of Benefits

Medical Expense Benefits
IHECT-MD-GOLD ENHANCED 1 – Student Plan
2016-202970-67
Metallic Level – Gold with Actuarial Value of 81.755%
Injury and Sickness Benefits

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

Deductible Preferred Providers	**$250 (Per Insured Person, Per Policy Year)**
Deductible Out of Network	**$600 (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	**$6,850 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Providers	**$13,700 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out of Network	**$15,000 (Per Insured Person, Per Policy Year)**

The Preferred Provider for this plan 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. See the Preferred Provider Information section for Out-of-Network provider access and payment information in certain circumstances. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network per service Deductibles.

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

Inpatient	Preferred Provider	Out-of-Network
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges

Inpatient	Preferred Provider	Out-of-Network
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network
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.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	100% of Preferred Allowance $25 Copay per visit	80% of Usual and Customary Charges
Chiropractic Services	Preferred Allowance	Usual and Customary Charges
Habilitative Services See also Benefits for Habilitative Services for Children.	Preferred Allowance	Usual and Customary Charges
Rehabilitative Services	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses The Copay/per visit Deductible will be waived if admitted to the Hospital. See Out-of-Network Emergency Services, page 3.	Preferred Allowance $150 Copay per visit	80% of Usual and Customary Charges $150 Deductible per visit
Diagnostic X-Ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs When a Prescription Drug is classified as a Maintenance Medication according to Maryland law and as written by the Physician. Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug and thereafter, up to a consecutive 90 day supply of a Prescription Drug subject to a Copay/Deductible per prescription at 2.5 times the Copay/Deductible for a 31 day supply. The applicable Copay, Deductible and/or Coinsurance will never be greater than the cost of the Prescription Drug.	Prescription Drugs from a Retail or Mail-Order UnitedHealthcare Pharmacy (UHCP) $20 Copay per prescription for Tier 1 $40 Copay per prescription for Tier 2 $65 Copay per prescription for Tier 3 up to a 31 day supply per prescription	$15 Deductible per prescription for generic drugs $35 Deductible per prescription for brand name up to a 31 day supply per prescription

Other	Preferred Provider	Out-of-Network
Ambulance Services	Preferred Allowance	80% of Usual and Customary Charges

Other	Preferred Provider	Out-of-Network
Durable Medical Equipment	Preferred Allowance	80% of Usual and Customary Charges
Consultant Physician Fees	100% of Preferred Allowance $25 Copay per visit	80% of Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Preferred Allowance	80% of Usual and Customary Charges
Mental Illness and Substance Use Disorder Treatment	Paid as any other Sickness	Paid as any other Sickness
Maternity See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion $1,000 maximum per Policy Year	Preferred Allowance	Usual and Customary Charges
Preventive Care Services No Deductible or Copays will be applied to Preventive Care Services.	100% of Preferred Allowance	80% of Usual and Customary Charges
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following a Mastectomy	Preferred Allowance	Usual and Customary Charges
Diabetes Services	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Preferred Allowance	Usual and Customary Charges
Hospice Care	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	Preferred Allowance $50 Copay per visit	Usual and Customary Charges $50 Deductible per visit
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Cardiac Rehabilitation	Preferred Allowance	Usual and Customary Charges
Family Planning	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids	Preferred Allowance	Usual and Customary Charges
Infertility Services	Paid as any other Sickness	Paid as any other Sickness
Medical Foods	Preferred Allowance	Usual and Customary Charges
Nutritional Services	Paid as any other Sickness	Paid as any other Sickness
Patient Centered Medical Care Coordination	Paid as any other Sickness	Paid as any other Sickness
Pulmonary Rehabilitation	Paid as any other Sickness	Paid as any other Sickness
Wellness Program Benefits	Up to $200 per 6 month period	Up to $200 per 6 month period
Wigs	Preferred Allowance	Usual and Customary Charges
Pediatric Dental and Vision Services	See benefit description for Pediatric Dental Services Benefits and Vision Care Services Benefits	See benefit description for Pediatric Dental Services Benefits and Vision Care Services Benefits
Repatriation	See benefit description for UnitedHealthcare Global: Global Emergency Services	See benefit description for UnitedHealthcare Global: Global Emergency Services
Medical Evacuation	See benefit description for UnitedHealthcare Global: Global Emergency Services	See benefit description for UnitedHealthcare Global: Global Emergency Services
Accidental Death and Dismemberment ($1,250 - $5,000)	See benefit description for Accidental Death and Dismemberment Benefits	See benefit description for Accidental Death and Dismemberment Benefits

Other	Preferred Provider	Out-of-Network
Titers: Coverage only includes titers related to immunizations for the following: Polio Virus Immune status, Varicella-Zoster AB, IgG, Hepatitis B surf AB, Quantiferon tube test (Tuberculosis screening), MMR, Hep B, Hep A, Tdap, Tuberculosis testing, and Rubella. All Deductibles and Copays will be waived and benefits will be paid at 100% when treatment is rendered at the Student Health Center.	Preferred Allowance	Usual and Customary Charges