

UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for Students of

Washington State University



This Certificate of Coverage is Part of Policy # 2022-312-4

This Certificate of Coverage ("Certificate") is part of the contract between UnitedHealthcare Insurance Company (hereinafter referred to as the "Company," "We," "Us," and "Our") and the Policyholder.

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

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS THE INSURED PERSON'S RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.



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Introduction

Welcome to the UnitedHealthcare StudentResources Student Health Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company.

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

Nothing contained in the Certificate is designed to restrict the Insured Person in selecting the provider of their choice for care or treatment of a Sickness or Injury.

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

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

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 1-800-767-0700 or visiting us at www.uhcsr.com.

Women's Right to Direct Access for Women's Health Care Services

Women have direct access to all covered women's health care services. Women's health care services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, within the practitioner's scope of practice. The maternity care, reproductive health, and preventive services include contraceptive services, testing and treatment for sexually transmitted diseases, breast-feeding and complications of pregnancy.

Section 1: Who Is Covered

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

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

International Students with non-immigrant J1 and F1 status visas will be automatically enrolled in the plan unless an exemption is granted. Only students who fit into one of the following categories may be exempt from enrollment in the iSHIP plan; Student enrolled in a medical insurance plan sponsored by a United States employer of themselves or a family member (parent, spouse/partner). Students enrolled at WSU but conducting research outside of the United States.

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

The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

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

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
 - a. On the date the Named Insured acquires a legal spouse or a Domestic Partner who meets the specific requirements set forth in the Definitions section of this Certificate.

- b. On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the Definitions section of this Certificate.

Dependent eligibility expires concurrently with that of the Named Insured.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 16, 2022. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 15, 2023. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

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

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

Special Enrollment Period

Eligible students and their eligible Dependents can also enroll for coverage within 60 days of any of the following qualifying events.

1. Loss of minimum essential coverage under another health plan. This does not include loss of coverage due to an individual's misrepresentation of a material fact affecting coverage, fraud related to the discontinued health coverage, or failure to pay premiums.
2. Loss of eligibility for Medicaid or a public program providing health benefits.
3. Loss of coverage due to dissolution of marriage or termination of a domestic partnership.
4. Loss of coverage due to the death of an employee when covered as a dependent under the employee's health plan.
5. Loss of coverage under another health plan due to termination or reduction of work hours.
6. Permanent change in residence, work, or living situation, whether or not within the choice of the individual, where the health plan under which the individual was covered does not provide coverage in that person's new service area.
7. Birth, adoption or placement for adoption of a dependent child.
8. A health plan no longer offers any benefits to the class of similarly situated individuals that includes the eligible person.
9. Coverage is discontinued in a qualified health plan by the health benefit exchange and the three month grace period for continuation of coverage has been exhausted.
10. Exhaustion of COBRA coverage due to failure of the employer to remit premium.
11. Loss of COBRA coverage where the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available.
12. Discontinuation of coverage under the Washington State Health Insurance Pool (WSHIP).
13. Loss of coverage as a dependent on a group plan due to age.
14. Marriage or entering into a domestic partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership.

Coverage under the policy will become effective depending on when eligible person's enrollment and the premium are received by the Company.

1. If the individual's enrollment and premium are received between the first and fifteenth day of the month, the coverage will begin on the first day of the following month.
2. If the individual's enrollment and premium are received between the sixteenth day and the last day of the month, the coverage will begin on the first day of the second month.
3. For special enrollment of newborn, adopted or placed for adoption children, the date of birth, date of adoption or date of placement for adoption, as applicable, becomes the first effective date of coverage.
4. For special enrollment based on marriage or the beginning of a domestic partnership, and for special enrollment based on loss of minimum essential coverage, coverage becomes effective on the first day of the next month.

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 365 days for Injury or 90 days for Sickness after the Termination Date.

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

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

Section 4: Pre-Admission Notification

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

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

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

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

Section 5: Preferred Provider and Out-of-Network Provider Information

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

The provider network for this plan is Choice

Preferred Provider Hospitals include UnitedHealthcare Choice United Behavioral Health (UBH) facilities.

The easiest way to locate Preferred Providers is through the plan's website at www.uhcsr.com. The website will allow the Insured to easily search for providers by specialty and location.

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

The Company arranges for health care providers to take part in the Preferred Provider network. Preferred Providers are independent practitioners. They are not employees of the Company. It is the Insured's responsibility to choose a provider. Our credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided.

A provider's status may change. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling Customer Service at 1-800-767-0700 and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com.

If an Insured receives a Covered Medical Expense from an Out-of-Network Provider and was informed incorrectly by the Company prior to receipt of the Covered Medical Expense that the provider was a Preferred Provider, either through Our provider directory or in Our response to the Insured's request for such information (via telephone, electronic, web-based or internet-based means), the Insured may be eligible for cost-sharing (Copayment, Coinsurance, and applicable Deductible) that would be no greater than if the service had been provided from a Preferred Provider.

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-800-767-0700 to find out if they are eligible for continuity of care benefits.

"Preferred Provider Benefits" apply to Covered Medical Expenses that are provided by a Preferred Provider.

"**Out-of-Network Provider Benefits**" apply to Covered Medical Expenses that are provided by an Out-of-Network Provider.

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

Allowed Amounts are the amounts the Company will pay for Covered Medical Expenses. Refer to the definition of Allowed Amount in this Certificate for information on how the Company determines Allowed Amounts.

Preferred Provider Benefits

The Insured is not responsible for any difference between what the Company pays for Allowed Amounts and the amount the provider bills, except for the Insured Person's cost share obligation as specified in the Schedule of Benefits.

This Certificate includes the following provisions to comply with the applicable requirements of the *Consolidated Appropriations Act (the "Act") (P. L. 116 -260)*. These provisions reflect requirements of the Act; however, they do not preempt applicable state law.

Out-of-Network Provider Benefits

Except as described below, the Insured Person is responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the provider bills the Insured and the amount the Company pays for Allowed Amounts.

1. For Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
2. For non-Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied in accordance with applicable law, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
3. For Emergency Services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the Recognized Amount as defined in this Certificate.
4. For Air Ambulance services provided by an Out-of-Network Provider, the Insured is not responsible, and the Out-of-Network Provider may not bill the Insured, for amounts in excess of the Insured's applicable Copayment, Coinsurance, or Deductible which is based on the rates that would apply if the service was provided by a Preferred Provider which is based on the Recognized Amount as defined in this Certificate.

For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the *Social Security Act*), and any other facility specified by the Secretary.

Right to a Second Opinion

Upon request, the Insured Person has access to a second opinion regarding any medical diagnosis or treatment plan from a Preferred Provider of the Insured's choice. Benefits will be paid the same as for any other Covered Medical Expense in otherwise similar circumstances.

Continuity of Care

In the event a contract or agreement between the Company and a Preferred Provider Physician is terminated by the Company, an Insured under this plan may continue to receive care from that provider at the Preferred Provider level of benefits until the end of sixty (60) days following notice of termination to the Insured Person.

Out-of-Network Preventive Care Services

If the Policy does not have in its PPO network a Preferred Provider who can perform the particular Preventive Care Service, the Policy will cover the item or service when performed by an Out-of-Network Provider and will not impose cost-sharing with respect to the item or service.

Section 6: Medical Expense Benefits

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

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

Benefits are payable for services delivered via Telemedicine/Telehealth. Benefits for these services are provided to the same extent as an in-person service under any applicable benefit category in this section.

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:

ESSENTIAL HEALTH BENEFITS: The following benefits are considered Essential Health Benefits.

Inpatient

1. **Room and Board Expense.**

Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital. Benefits include a private room when the Insured presents to a facility that only has private rooms available for treatment.

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.

Benefits will be paid for services and supplies such as:

- The cost of the operating room.
- Facility fee charges.
- Laboratory tests.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services, including dialysis services.
- Supplies.

4. **Routine Newborn Care.**

Nursery services and supplies while Hospital Confined and routine nursery care provided immediately after birth for a Newborn Infant including newly adopted children.

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

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

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

5. **Surgery.**

Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**

Professional services administered in connection with Inpatient surgery.

8. **Registered Nurse's Services.**

Registered Nurse's services which are all of the following:

- Private duty nursing care only.
- Received when confined as an Inpatient.
- Ordered by a licensed Physician.
- A Medical Necessity.

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

9. **Physician's Visits.**

Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:

- Complete blood count.
- Urinalysis.
- Chest X-rays.

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

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

Outpatient

11. **Surgery.**

Physician's fees for outpatient surgery.

12. **Day Surgery Miscellaneous.**

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

13. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with outpatient surgery.

14. **Anesthetist Services.**

Professional services administered in connection with outpatient surgery.

15. **Physician's Visits.**

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

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

16. **Physiotherapy.**

Includes but is not limited to the following rehabilitative services (including Habilitative Services):

- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid to restore or improve lost function caused by Injury or Sickness.

Physiotherapy provided in the Insured Person's home by a home health agency is provided as specified under Home Health Care. Physiotherapy provided in the Insured's home other than by a home health agency is provided as specified under this benefit.

17. **Medical Emergency Expenses.**

Only in connection with a Medical Emergency as defined. Benefits will be paid for:

- The facility charge for use of the emergency room and supplies.

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

18. **Diagnostic X-ray Services.**

Means diagnostic imaging (including MRI, CAT Scan, PET Scan, nuclear medicine and diagnostic ultrasound imaging) procedures performed by a Physician on an outpatient basis. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.

19. **Radiation Therapy.**

See Schedule of Benefits.

20. **Laboratory Procedures.**

Means laboratory and pathology procedures performed by a Physician on an outpatient basis. Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures include blood, blood products, blood storage, and services and supplies provided by a blood bank. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

21. **Tests and Procedures.**

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

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

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

- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.
- Outpatient dialysis services.
- Colonoscopies.
- Cardiovascular testing.
- Pulmonary function studies.
- Neurology/neuromuscular procedures.

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

22. **Injections.**

When administered in the Physician's office and charged on the Physician's statement, including therapeutic injections and related supplies. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy.**

See Schedule of Benefits.

24. **Prescription Drugs.**

See Schedule of Benefits.

Teaching doses of self-administered injectable medications are limited to three doses per medication per lifetime. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Benefits will also be provided for one early refill of a prescription for topical ophthalmic products without consulting a Physician or obtaining a new prescription if all of the following criteria are met:

- The refill is required by an Insured at or after 70% of the predicted days of use of either the date the original prescription was dispensed or the date the last refill of the prescription was dispensed.
- The prescriber indicates on the original prescription that a specific number of refills will be needed.

- The refill does not exceed the number of refills that the prescriber indicated on the original prescription.

Other

25. Ambulance Services.

See Schedule of Benefits.

26. Durable Medical Equipment.

Durable Medical Equipment must be all of the following:

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

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

- Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts.
- Durable medical equipment and mobility enhancing equipment used to serve a medical purpose.
- Cochlear implants.

Benefits include state sales tax for durable medical equipment.

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

27. Consultant Physician Fees.

Services provided on an Inpatient or outpatient basis.

28. Dental Injury.

Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.
- Removal of impacted wisdom teeth.

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

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

29. Dental Treatment.

Dental services or appliances for, or resulting from medical treatment, including oral surgery related to trauma or Injury, if the service is either:

- Emergency in nature.
- Required for extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.

Benefits are also available for Inpatient and outpatient facility and general anesthesia charges when hospitalization is determined to be necessary to safeguard the Insured Person's health while dental services are performed. Benefits do not include charges for the dentist or services received in a dentist's office.

30. Mental Illness Treatment.

See Benefits for Mental Disorders and Substance Use Disorders. Benefits for Mental Illness Treatment include coverage for eating disorder treatment when associated with a diagnosis of a DSM categorized mental health condition.

31. Substance Use Disorder Treatment.

See Benefits for Mental Disorders and Substance Use Disorders.

32. Maternity.

Benefits include all maternity-related services for the following:

- Prenatal and postnatal care and services, including screening.
- Vaginal or cesarean childbirth in a Hospital or birthing center, including the facility fees.
- Coverage of a home birth by a midwife or nurse midwife.
- In-utero treatment for the fetus.
- Prenatal vitamins for a pregnant Insured Person.
- Breast pump for an Insured Person expecting the birth or adoption of a child.
- Medically Necessary screening and diagnostic procedures for prenatal diagnosis of congenital disorders, including all of the following:
 - Hepatitis B surface antigen (HBsAg) screening for the Insured Person during the first trimester of pregnancy and the last trimester of pregnancy if the Insured Person is at high risk for hepatitis B infection.
 - Group B strep screening through prenatal vaginorectal cultures at thirty-five to thirty-seven weeks of gestation. The Insured Person who is currently colonized with Group B strep, or who have unknown Group B strep status, should receive intrapartum treatment in accordance with the current standard of practice in order to reduce risk to the newborn.
 - Maternal serum marker screening for the Insured Person at the beginning of prenatal care if initiated before the twenty-second completed week of gestation.
 - Prenatal ultrasonography during both:
 - The first trimester to establish viability, gestational age, and determine singleton or multiple births.
 - The second trimester for fetal morphology.
 - Additional prenatal ultrasonography at any time during a pregnancy if one or more of the following criteria are met:
 - An Insured Person is undergoing amniocentesis, chorionic villus sampling, or percutaneous umbilical cord blood sampling, or fetal tissue biopsy.
 - The results of a maternal serum marker screening or prenatal cell free DNA test indicates an increased risk to the fetus or pregnancy.
 - There is an increased risk of a congenital abnormality present due to:
 - Environmental exposure.
 - Medical evaluation indicating the possibility of polyhydramnios, oligohydramnios, or poor or accelerated fetal growth.
 - A personal or family history of a congenital abnormality that is potentially detectable by prenatal ultrasound.
 - Amniocentesis after fourteen weeks of gestation.
 - Chorionic villus sampling between ten and fourteen weeks of gestation.
 - Specific fetal diagnostic testing including:
 - Cytogenetic studies on fetal cells including chromosome analysis, targeted cytogenomic microarray analysis (CMA), and fluorescent in-situ hybridization (FISH) for any person undergoing amniocentesis or chorionic villus sampling.
 - DNA testing, biochemical testing, or testing for infectious diseases if medically indicated because of an abnormal ultrasound finding, intrauterine fetal demise, or known family history.
 - Cytogenomic microarray analysis in the case of recurrent intrauterine fetal demise, or known family history.
 - Prenatal cell free DNA testing performed after nine weeks of gestation for the detection of aneuploidy including trisomy 21, 18, 13 or the sex chromosomes when specific criteria is met.
 - Carrier screening, limited to once per lifetime, at any time during the pregnancy for recessive or x-linked conditions if indicated by a positive family history and for any of the following conditions irrespective of family history:
 - Alpha-thalassemia (HBA1/HBA2).
 - Beta-thalassemia.
 - Bloom syndrome.
 - Canavan disease.
 - Cystic fibrosis.
 - Familial dysautonomia (IKBKAP).
 - Fanconi anemia type C (FANCC).
 - Gaucher disease (GBA).
 - Mucopolysaccharidosis IV (MPS4).
 - Niemann-Pick disease (SMPD1).
 - Sickle cell disease.
 - Spinal muscular atrophy (SMN1).
 - Tay-Sachs disease (HEXA).
 - Fragile-X Syndrome.
 - Molecular genetic or cytogenetic testing of parents to allow for definitive fetal testing, or parental testing to better inform results that are suggestive of, but do not identify, a unifying diagnosis and when the results or

the parental testing will be used to guide treatment, reproductive decisions, or care planning that would not otherwise be made.

- Percutaneous umbilical cord blood sampling after fifteen weeks of gestation if one or more of the following criteria are met:
 - A medical evaluation indicates rapid or specific submicroscopic chromosomal diagnosis or DNA diagnosis is required to predict prognosis for the fetus.
 - A medical evaluation indicates the possibility of a prenatally diagnosable fetal infection.
 - Fetal blood studies are medical indicated for isoimmunization studies or therapy.
 - Fetal blood is the only means to provide biochemical genetic diagnosis.
 - Prenatal diagnosis of a hematological disorder is medically indicated.
- Prenatal tissue biopsy if the nature of the disorder in question indicated that fetal liver, skin, or other tissue biopsy is the only means to provide biochemical genetic diagnosis to protect the health of the Insured Person or predict the prognosis of the fetus.
- Cytogenomic microarray analysis (CMA) if medical indicated because of an abnormal ultrasound finding or known family history.

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

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

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

Benefits will be provided for abortion of a pregnancy subject to the Policy terms and conditions applicable to Maternity, including applicable Deductibles, Copayments and Coinsurance.

33. Complications of Pregnancy.

Benefits include services performed for complications such as, but not limited to, fetal distress, gestational diabetes, and toxemia.

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*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Required preventive care services are updated on an ongoing basis as guidelines and recommendations change. The complete and current list of preventive care services covered under the health care reform law can be found at: <https://www.healthcare.gov/preventive-care-benefits/>.

Preventive care services include screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault

Preventive care services for adults:

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use to prevent cardiovascular and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk.
- Blood pressure screening.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults 45 and older.
- Depression screening for adults.
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese.
- Diet/nutrition counseling for adults at higher risk for chronic disease.

- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting.
- Hepatitis B screening for people at high risk, including people from countries with 2 % or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.
- Hepatitis C screening for adults age 18 to 79.
- HIV screening for everyone ages 15 to 65, and other ages at increased risk.
- Immunization vaccines for adults – doses, recommended ages and recommended populations vary.
- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.
- Obesity screening and counseling for all adults, including intensive, multicomponent behavioral weight-loss interventions.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use.
- Preventive care services include screening for physical, mental, sexual, and reproductive health care needs that arise from a sexual assault.
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk.
- Skin cancer behavioral counseling up to age 24 for adults with fair skin types.
- Statin preventive medication for adults 40 to 75 at high risk.
- Syphilis screening for all adults at higher risk.
- Tobacco use screening and counseling for all adults and cessation interventions, including medications for tobacco use cessation, for tobacco users.
- Tuberculosis screening for certain adults without symptoms at high risk.

Preventive care services for women:

- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause.
- Breast cancer genetic test counseling (BRCA) for women at higher risk for breast cancer.
- Breast cancer mammography screenings every 2 years for women 50 and over and as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies and equipment, for pregnant and nursing women.
- Cervical cancer screening for women age 21 to 65.
- Chlamydia infection screening for younger women and other women at higher risk.
- Contraception: Food and Drug Administration-approved contraceptive methods, including insertion or extraction of FDA-approved contraceptive devices, sterilization procedures, including prescription-based sterilization procedures and patient education and counseling, as prescribed by a Physician for women with reproductive capacity (not including abortifacient drugs).
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 weeks pregnant or later and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.
- HIV screening and counseling for everyone ages 15 to 65, and other ages at increased risk.
- Maternal depression screening for mothers at well-baby visits.
- Osteoporosis screening for women over age 60 depending on risk factors.
- Prenatal and postpartum depression screening.
- Preeclampsia prevention and screening for pregnant women with high blood pressure.
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Sexually transmitted infections screening and counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Tobacco use screening and interventions, including medications for tobacco use cessation, for all women, and expanded intervention and counseling for pregnant tobacco users.
- Urinary incontinence screening.
- Urinary tract or other infection screening for pregnant women.
- Well-woman visits to get recommended services.

Preventive care services for children:

- Alcohol, tobacco and drug use assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Bilirubin concentration screening for newborns.
- Blood pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood screening for newborns.
- Depression screening for adolescents beginning routinely at age 12.
- Developmental screening for children under age 3.
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders.
- Fluoride supplements for children without fluoride in their water source.
- Fluoride varnish for all infants and children as soon as teeth are present.
- Gonorrhea prevention medication for the eyes of all newborns.
- Hearing screening for all newborns and regular screenings for children as recommended by their Physician.
- Height, weight and body mass index (BMI) measurements taken regularly for all children.
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hepatitis B screening for adolescents at higher risk.
- HIV screening for adolescents at higher risk.
- Hypothyroidism screening for newborns.
- Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary.
- Lead screening for children at risk of exposure.
- Obesity screening and counseling, including behavioral management activities such as weight-loss goals.
- Oral health risk assessment for young children from ages: 6 months to 6 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use.
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk.
- Skin cancer behavioral counseling for ages 6 months to 24 years with fair skin types.
- Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children.
- Well-baby and well-child visits.

35. **Reconstructive Breast Surgery Following Mastectomy.**

Reconstructive breast surgery in connection with a covered mastectomy. Benefits include coverage for mastectomy bras and physical complications, such as lymphedemas. See Benefits for Reconstructive Breast Surgery.

36. **Diabetes Services.**

Services received in connection with the treatment of diabetes. See Benefits for Diabetes.

37. **Home Health Care.**

Services received from a licensed home health agency that are:

- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person's home.
- Pursuant to a home health plan.

Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.

Benefits will also be paid for home dialysis services.

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. All hospice care must be received from a licensed hospice agency.

Hospice care includes:

- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.
- Respite care.

39. Inpatient Rehabilitation Facility.

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

40. 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.

Benefits include facility costs, professional and pharmacy services, and prescriptions filled in the Skilled Nursing Facility.

41. Urgent Care Center.

Benefits are limited to:

- The facility or clinic fee and supplies billed by the Urgent Care Center.

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

42. Hospital Outpatient Facility or Clinic.

Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

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

43. Approved Clinical Trials.

Routine Patient Care Costs incurred while taking part 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 funded by or described in any of the following:

- One of the National Institutes of Health (NIH).
- An NIH cooperative group or center which is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.
- The federal Departments of Veterans Affairs or Defense.

- An institutional review board of an institution in this state that has a multiple project assurance contract approval by the Office of Protection for the Research Risks of the NIH.
- A qualified research entity that meets the criteria for NIH Center Support Grant eligibility.
- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

44. **Transplantation Services.**

Organ or tissue transplants, including artificial organ transplants, when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense. Benefits include transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a Hospital setting or outpatient setting.

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

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

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

45. **Pediatric Dental and Vision Services.**

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

46. **Acupuncture Services.**

See Schedule of Benefits. If a visit limit is specified in the Schedule of Benefits, the limit will not be applied to acupuncture services for the treatment of chemical dependency.

47. **Genetic Testing.**

Benefits are limited to genetic testing following genetic counseling when ordered by a Physician and which is determined to be Medically Necessary.

48. **Infertility.**

Benefits are limited to the diagnosis of the underlying causes of infertility.

49. **Medical Foods.**

Medical foods must meet all of the following criteria:

- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of inborn errors of metabolism.

See also Benefits for Phenylketonuria Treatment and Eosinophilic Gastrointestinal Associated Disorder.

50. **Neurodevelopmental Therapy.**

Inpatient and outpatient neurodevelopment services for Insureds with a Neurodevelopmental Delay. For the purpose of this provision, neurodevelopmental delay means a delay in normal development that is not related to any documented Injury or Sickness. Covered services include:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Maintenance services, if significant deterioration of the Insured's condition would result without the service.

This benefit will not duplicate benefits provided under outpatient Physiotherapy for the same service for the same condition.

51. **Nutritional Counseling.**

Benefits are payable for Medically Necessary nutritional counseling for medical conditions when supported by evidence based medical criteria.

Section 7: Mandated Benefits

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY

Benefits will be provided for reconstructive breast surgery (including prosthesis) resulting from a mastectomy which resulted from disease, illness, or Injury; regardless of when the mastectomy or the condition which made the mastectomy necessary was covered by the Policy.

Benefits will be paid for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. Benefits for reconstructive breast surgery shall be commensurate with the Hospital and surgical benefits otherwise provided by the Policy.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations or other provisions of the Policy.

BENEFITS FOR MENTAL DISORDERS AND SUBSTANCE USE DISORDERS

Benefits will be provided for the diagnosis and treatment of Mental Disorders and Substance Use Disorders, including all of the following:

1. Inpatient, residential and outpatient treatment, including partial Hospital programs or inpatient services and home health care services.
2. Chemical dependency detoxification.
3. Behavioral treatment for a *Diagnostic and Statistical Manual of Mental Disorders (DSM)* category diagnosis.
4. Services provided by a licensed behavioral health provider for a covered diagnosis in a Skilled Nursing Facility.
5. Prescription Drugs, including those drugs prescribed during an Inpatient and residential course of treatment.
6. Acupuncture treatment visits without application of any visit limitation requirements, when provided for chemical dependency.
7. Family counseling when the Insured is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for a Mental Disorder.
8. Mental health treatment for diagnostic codes 302 through 302.9 in the DSM, or the "V code" diagnoses for Medically Necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child or children five years of age or younger, and bereavement for children five years of age or younger.
9. Gender dysphoria.
10. Medically Necessary court-ordered Mental Disorder treatment.
11. Treatment and supporting services for Substance Use Disorder, including Withdrawal Management Services or Inpatient or residential Substance Use Disorder treatment services in a licensed or certified behavioral health agency.
12. Services delivered pursuant to involuntary commitment proceedings.

For the purposes of this benefit, "Medical Necessity/Medically Necessary":

1. With regard to chemical dependency and Substance Use Disorders is defined by the most recent version of *The ASAM Criteria, Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions* as published by the American Society of Addictive Medicine (ASAM).
2. With regard to Mental Health Services, pharmacy services, and any Substance Use Disorder benefits not governed by ASAM is a Company determination as to whether a health service is a Covered Medical Expense because the service is consistent with generally recognized standards within a relevant health profession.

"Mental health services" means Medically Necessary outpatient and Inpatient services provided to treat Mental Disorders covered by the diagnostic categories listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association consistent with the purposes of chapter 6, Laws of 2005.

"Withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery.

Benefits will be paid as specified in the Policy Schedule of Benefits for Mental Illness Treatment and Substance Use Disorder Treatment and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR DIABETES

Benefits will be provided for the following services and supplies for Insured Persons with diabetes:

1. Medically Necessary equipment and supplies, as prescribed by a Physician, including but not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits.
2. Outpatient self-management training and education, including medical nutrition therapy, as ordered by the Physician. Diabetes outpatient self-management training and education must be provided by providers with expertise in diabetes.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR MAMMOGRAPHY

Benefits will be provided for screening or diagnostic mammography when recommended by a Physician, advanced registered nurse practitioner, or physician assistant.

Mammography covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule of Benefits.

Mammography not covered by the Preventive Care Services benefit will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be provided for prostate cancer screening when recommended by a Physician.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR PHENYLKETONURIA TREATMENT AND EOSINOPHILIC GASTROINTESTINAL ASSOCIATED DISORDER

Benefits will be provided for the mineral and vitamin-enriched formulas necessary for the treatment of phenylketonuria and use of Medically Necessary elemental formula for eosinophilic gastrointestinal associated disorder.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR SELF-ADMINISTERED ANTICANCER MEDICATIONS

Benefits will be provided for prescribed, self-administered anticancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than for cancer chemotherapy medications that are Covered Medical Expenses under the Policy.

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

BENEFITS FOR ALTERNATIVE CARE FOR HOSPITAL CONFINEMENT

If benefits are provided for Hospital Confinement or institutional expenses, benefits will be provided, at equal or lesser cost, for substitution of home health care, in lieu of Hospital Confinement; furnished by home health, hospice and home care agencies licensed under state statute. These benefits are provided as an alternative to Hospital Confinement and institutional expenses and with the intent to cover placement of an Insured in the most appropriate and cost-effective setting.

Substitution of less expensive or less intensive services shall be made only with the consent of the Insured and receipt of a written treatment plan approved by the Insured's treating Physician recommending such care.

Benefits will be limited to the maximum benefits which would be payable for Hospital Confinement.

Benefits will be subject to all Deductibles, Copayments, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER

Benefits will be provided for the treatment of temporomandibular joint disorders.

Benefits will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR OFF-LABEL PRESCRIPTION DRUGS

Benefits will be paid the same as any other Prescription Drug prescribed to treat an Insured resident in the state of Washington when that drug has not been approved by the Federal Food and Drug Administration for that indication, if such drug is recognized as effective for treatment:

1. In one of the Standard Reference Compendia.
2. In the majority of relevant Peer-Reviewed Medical Literature if not recognized in one of the Standard Reference Compendia.
3. By the Federal Secretary of Health and Human Services

Benefits will include Medically Necessary services associated with the administration of the Prescription Drug.

Benefits will not be paid for:

1. The use of any Drug when the FDA has determined that use to be contraindicated
2. Any experimental Drug not otherwise approved for any indication by the FDA.

"Off-label" means the prescribed use of a drug which is other than that stated in its FDA approved labeling.

"Peer-Reviewed Medical Literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

"Standard Reference Compendia" means:

1. The American Hospital Formulary Service-Drug Information;
2. The American Medical Association Drug Evaluation;
3. The United States Pharmacopoeia-Drug Information; or
4. Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the insurance commissioner.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be provided for colorectal cancer examinations and laboratory tests consistent with the guidelines or recommendations of the United States Preventive Services Task Force or the federal centers for disease control and prevention.

Benefits will be provided for any colorectal screening examination and test in the selected guidelines or recommendations, at a frequency identified in such guidelines or recommendations, as deemed appropriate by the Insured Person's Physician after for an Insured who is either:

1. At least fifty (50) years of age.
2. Less than fifty (50) years of age and at high risk for colorectal cancer according to such guidelines and recommendations.

If a Preferred Provider is not available to administer colorectal cancer screening services, benefits will be paid at the level of benefits shown as Preferred Provider benefits listed in the Schedule of Benefits.

Colorectal cancer screening covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule of Benefits.

Colorectal cancer screening not covered by the Preventive Care Services benefit will be provided in the same manner and at the same level as those for any other Covered Medical Expense and will be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR CONTRACEPTIVES

Benefits will be provided for prescription contraceptives approved by the United States Food and Drug Administration (FDA) on a basis no less favorable than for other covered Prescription Drugs and devices. Benefits will be provided for the medical

services associated with prescribing, dispensing, delivery, distribution, administration and removal of a prescription contraceptive to the same extent, and on the same terms, as other outpatient services.

Prescription contraceptives include FDA approved Contraceptive Drugs, devices, and prescription barrier methods, including contraceptive products declared safe and effective for use as emergency contraception by the FDA.

Benefits will be provided for up to a 12-month refill supply of prescription Contraceptive Drugs when prescribed to be dispensed at one time, unless the Insured requests a smaller supply or the prescribing Physician instructs that the Insured must receive a smaller supply. If a 12-month refill extends beyond the Policy termination date, benefits will be provided for the number of months up to the Policy termination date.

The Insured Person may receive the Contraceptive Drug on-site at the Physician's office, if available.

"Contraceptive Drugs" means all drugs approved by the FDA that are used to prevent pregnancy, including but not limited to, hormonal drugs administered orally, transdermally, and intravaginally.

Benefit will also be provided for the following contraceptive methods:

1. All over-the-counter contraceptive drugs, devices, and other products approved by the FDA. This includes condoms, regardless of the gender or sexual orientation of the Insured Person, and regardless of whether they are to be used for contraception or exclusively for the prevention of sexually transmitted infections.
2. Voluntary sterilization procedures.
3. The consultations, examinations, procedures, and medical services that are necessary to prescribe, dispense, insert, deliver, distribute, administer, or remove the drugs, devices and other products or services specified in 1 and 2 above.

No prescription is required for over-the-counter contraceptive drugs, devices, and products approved by the FDA.

Benefits will not be denied because an Insured changed his or her contraceptive method within a twelve-month period.

Benefits apply to all Insured Person's and will not be denied on the basis of race, color, national origin, sex, sexual orientation, gender expression or identity, marital status, age, citizenship, immigration status, or disability.

Prescription contraceptives covered by the Preventive Care Services Benefit shall be paid as specified in the Preventive Care Services Benefit listed in the Schedule of Benefits. Contraceptive methods received from a Preferred Provider shall not be subject to a Deductible, Copayment or Coinsurance. When received from an Out-of-Network Provider, contraceptive benefits shall be subject to all Deductible, Copayment, Coinsurance limitations or any other provisions of the Policy.

BENEFITS FOR HEALTH CARE NEEDS FROM A SEXUAL ASSAULT

Benefits will be paid the same as any other Sickness for the Medically Necessary services and Prescription Drugs for the treatment of physical, mental, sexual and reproductive health care needs that arise from a sexual assault of an Insured Person.

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

BENEFITS FOR GENDER AFFIRMING TREATMENT

Benefits will be paid the same as any other Sickness for Medically Necessary Gender Affirming Treatment when prescribed to an Insured because of, related to, or consistent with the Insured Person's gender expression or identity and in accordance with accepted standards of care.

Benefits will include Medically Necessary cosmetic procedures and services in relation to Gender Affirming Treatment.

"Gender affirming treatment" means a service or product that a health care provider, as defined in RCW 70.02.010, prescribes to an individual to treat any condition related to the individual's gender identity and is prescribed in accordance with generally accepted standards of care. Gender affirming treatment must be covered in a manner compliant with the federal mental health parity and addiction equity act of 2008 and the federal affordable care act. Gender affirming treatment can be prescribed to two spirit, transgender, nonbinary, intersex, and other gender diverse individuals.

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

Section 8: Excess Provision

Even if you have other insurance, the plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other group insurance. Benefits will be paid on the unpaid balances after your other group insurance has paid.

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

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

Other Valid and Collectible Insurance includes:

1. Group, individual or blanket insurance contracts and subscriber contracts.
2. Group and individual coverage through closed panel plans.

Other Valid and Collectible Insurance does not include:

1. Hospital indemnity coverage benefits or other fixed indemnity coverage.
2. Accident only coverage.
3. Specified disease or specified accident coverage.
4. Limited benefit health coverage.
5. School accident and similar 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.
6. 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;
7. Medicare supplement policies.
8. A state plan under Medicaid.
9. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
10. Automobile insurance policies required by statute to provide medical benefits.
11. Benefits provide as part of a direct agreement with a direct patient-provider primary care practice as defined by state law (section 3, chapter 267, Laws of 2007).

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

Section 9: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 12 months from the date of Injury solely result in any one of the following specific losses, the Company will pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

Life	\$	10,000
Two or More Members	\$	10,000
One Member	\$	5,000
Thumb or Index Finger	\$	5,000

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.

Section 10: Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student policy for at least one semester and who no longer meet the eligibility requirements under that policy are eligible to continue their coverage for a period of not more than 30 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

Section 11: Definitions

ADOPTED CHILD means the adopted child placed with an Insured while that person is covered under the Policy. Such child will be covered from the moment of placement for the first 60 days.

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. Coverage for a newborn adopted child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 60 days. If additional premium is required to continue the coverage, the Insured must, within the 60 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 60 days after the child's date of placement. The time limit on notifying the Company does not apply when additional premium is not required.

AIR AMBULANCE means medical transport by rotary wing air ambulance or fixed wing air ambulance as defined in 42 CFR 414.605.

ALLOWED AMOUNT means the maximum amount the Company is obligated to pay for Covered Medical Expenses. Allowed amounts are determined by the Company or determined as required by law, as described below.

Allowed amounts are based on the following:

When Covered Medical Expenses are received from a Preferred Provider, allowed amounts are the Company's contracted fee(s) with that provider.

When Covered Medical Expenses are received from an Out-of-Network Provider as described below, allowed amounts are determined as follows:

1. For non-Medical Emergency Covered Medical Expenses received at certain Preferred Provider facilities from Out-of-Network Provider Physicians when such services are either: a) Ancillary Services; or b) non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Health Service Act* with respect to a visit as defined by the Secretary, the allowed amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the *Social Security Act*), and any other facility specified by the Secretary.

2. For Emergency Services provided by an Out-of-Network Provider, the allowed amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
 - The amount determined by *Independent Dispute Resolution (IDR)*.
3. For Air Ambulance transportation provided by an Out-of-Network Provider, the allowed amount is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.

- The amount determined by *Independent Dispute Resolution (IDR)*.

When Covered Medical Expenses are received from an Out-of-Network Provider, except as described above, allowed amounts are determined based on either of the following:

1. Negotiated rates agreed to by the Out-of-Network Provider and either the Company or one of Our vendors, affiliates or subcontractors.
2. If rates have not been negotiated, then one of the following amounts:
 - Allowed amounts are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographical market, with the exception of the following.
 - 50% of CMS for the same or similar freestanding laboratory service.
 - 45% of CMS for the same or similar Durable Medical Equipment from a freestanding supplier, or CMS competitive bid rates.
 - 70% of CMS for the same or similar physical therapy service from a freestanding provider.
 - When a rate for all other services is not published by CMS for the service, the allowed amount is based on 20% of the provider's billed charge.

We update the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically put in place within 30 to 90 days after CMS updates its data.

ANCILLARY SERVICES means items and services provided by Out-of-Network Provider Physicians at a Preferred Provider facility that are any of the following:

1. Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
2. Provided by assistant surgeons, hospitalists, and intensivists.
3. Diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary.
4. Provided by such other specialist practitioners as determined by the Secretary.
5. Provided by an Out-of-Network Provider Physician when no other Preferred Provider Physician is available.

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

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

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

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

COVERED MEDICAL EXPENSES means health care services and supplies which are all of the following:

1. Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness or Injury.
2. Medically Necessary.
3. Specified as a covered medical expense in this Certificate under the Medical Expense Benefits or in the Schedule of Benefits.
4. Not in excess of the Allowed Amount or the Recognized Amount when applicable.
5. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
6. Not excluded in this Certificate under the Exclusions and Limitations.
7. In excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.

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

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

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

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

1. Incapable of self-sustaining employment by reason of developmental or physical disability.
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 after the two-year period 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 developmentally or physically disabled as defined by subsections (1) and (2).

DOMESTIC PARTNER means two persons who meet all of the following requirements:

1. Both persons share a common residence.
2. Both persons are at least eighteen years of age and at least one of the persons is sixty-two years of age or older.
3. Neither person is married to someone other than the party to the domestic partnership and neither person is in a state registered domestic partnership with another person.
4. Both persons are capable of consenting to the domestic partnership.
5. Both of the following are true:
 - a. The persons are not nearer of kin to each other than second cousins, whether of the whole or half-blood computing by the rules of the civil law.
 - b. Neither person is a sibling, child, grandchild, aunt, uncle, niece, or nephew to the other person.

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

EMERGENCY SERVICES means with respect to a Medical Emergency, all of the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.
2. Emergency room and department-based services, supplies, and treatment, including professional charges, facility costs, and outpatient charges for patient observation.
3. 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 or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).
4. Prescription Drugs associated with a Medical Emergency, including those purchased in a foreign country.

Emergency services include items and services otherwise covered under the Policy when provided by an Out-of-Network Provider or facility (regardless of the department of the Hospital in which the items and services are provided) after the patient is stabilized and as part of outpatient observation, or an Inpatient stay or outpatient stay that is connected to the original emergency medical condition, unless each of the following conditions are met:

1. The attending Physician or treating provider for the Medical Emergency determines the patient is able to travel using nonmedical transportation or non-emergency medical transportation to an available Preferred Provider or Preferred Provider facility located within a reasonable distance taking into consideration the patient's medical condition.
2. The provider furnishing the additional items and services satisfied the notice and consent criteria in accordance with applicable law.
3. The patient is in such a condition to receive information as stated in 2 above and to provide informed consent in accordance with applicable law.
4. The provider or facility satisfied any additional requirements or prohibitions as may be imposed by state law.

The above conditions do not apply to unforeseen or urgent medical needs that arise at the time the service is provided regardless of whether notice and consent criteria has been satisfied.

ESSENTIAL HEALTH BENEFITS means the following general categories and the items and services covered within the categories:

1. Ambulatory patient services.
2. Emergency services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

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

1. Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
3. The subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
4. In determining whether services are experimental or investigational, the Company will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.
5. In determining whether services are experimental or investigational, the Company will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient.

Exceptions:

1. Clinical trials for which Benefits are available as described under Approved Clinical Trials in Section 5: Medical Expense Benefits.
2. If the Insured Person is not a participant in a qualifying clinical trial, as described under Approved *Clinical Trials* in Section 5: Medical Expense Benefits, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment, the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first be established if there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

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, aural therapy, speech therapy, and other services for people with disabilities.

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

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

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

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

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT means a health care facility that: 1) is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and 2) provides Emergency Services.

INJURY means bodily injury which is all of the following:

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

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

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

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

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

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

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

MEDICAL EMERGENCY means a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain or emotional distress) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, Mental Disorder, or Substance Use Disorder attention and treatment would result in any of the following:

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

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

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

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

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

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

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

MENTAL DISORDER means a Sickness covered by the diagnostic categories listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. Mental disorders must be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the most current version of the *International Classification of Diseases (ICD)*, or state guidelines).

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

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 60 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 60 days. If additional premium is required to continue the coverage, the Insured must, within the 60 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 60 days after the child's birth. The time limit on notifying the Company does not apply when additional premium is not required.

OUT-OF-NETWORK PROVIDER means a provider who does not have a contract with the Company to provide services to Insured Persons.

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

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

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

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

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

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.
4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

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

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

PREFERRED PROVIDER means a provider that has a participation agreement in effect (either directly or indirectly) with the Company or Our affiliates to participate in Our preferred provider network. Our affiliates are those entities affiliated with the Company through common ownership or control with Us or with Our ultimate corporate parent, including direct and indirect subsidiaries.

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

RECOGNIZED AMOUNT means the amount which any Copayment, Coinsurance, and applicable Deductible is based on for the below Covered Medical Expenses when provided by Out-of-Network Providers:

1. Out-of-Network Emergency Services.
2. Non-Emergency Services received at certain Preferred Provider facilities by Out-of-Network Provider Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Health Service Act. For the purpose of this provision, "certain Preferred Provider facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

The amount is based on one of the following in order listed below as applicable:

1. An All Payer Model Agreement if adopted.
2. State law.
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The recognized amount for Air Ambulance services provided by an Out-of-Network Provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Medical Expenses that use the recognized amount to determine the Insured's cost sharing may be higher or lower than if cost sharing for these Covered Medical Expenses were determined based on an Allowed Amount.

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

SECRETARY means the term secretary as that term is applied in the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260).

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

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

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

SUBSTANCE USE DISORDER means a substance-related or addictive disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

TELEHEALTH/TELEMEDICINE means the delivery of health care services through the use of interactive audio and video technology, or audio-only technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include, facsimile, email or text messaging, unless the use of text-like messaging is necessary to ensure effective communication with individuals who have a hearing, speech, or other disability.. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work.

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.

Section 12: Exclusions and Limitations

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

1. Addiction, such as:
 - Caffeine addiction.
 - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
 - Codependency.
2. Learning disabilities.
This exclusion does not apply to the treatment of a Mental Disorder or Neurodevelopmental Therapy as specified in the Policy.
3. Biofeedback.
4. Circumcision.
5. Cosmetic procedures, except reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Treat or correct a congenital anomaly.
6. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
7. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - As described under Dental Treatment in the Policy.
 - As specifically provided in the Schedule of Benefits.
This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
10. Foot care for the following:
 - Supportive devices for the foot.
 - Routine foot care including the care, cutting and removal of corns, calluses and bunions (except capsular or bone surgery).
This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
11. Genetic testing, except as specifically provided in the Policy.
12. Health spa or similar facilities. Strengthening programs.
13. Hirsutism. Alopecia.
14. Hypnosis.
15. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
17. Injury sustained while:
 - Participating in any intercollegiate or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
18. Investigational services.
19. Lipectomy.

20. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
21. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
 - Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
22. Reproductive services for the following:
 - Procreative counseling.
 - Genetic counseling and genetic testing, except as specifically provided in the Policy.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose the underlying cause of the infertility.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Reversal of sterilization procedures.
23. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
24. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

This exclusion does not apply as follows:

 - When due to a covered Injury or disease process.
 - To benefits specifically provided in Pediatric Vision Services.
 - To benefits specifically provided in the Policy.
25. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the benefits for Routine Newborn Care.
26. Preventive care services which are not specifically provided in the Policy, including:
 - Routine physical examinations and routine testing.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
27. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
28. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except for orthognathic surgery due to temporomandibular joint disorder, Congenital Conditions, Injury and sleep apnea. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
29. Sleep disorders, except for orthognathic surgery due to sleep apnea.
30. Speech therapy, except as specifically provided in the Policy.
31. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
32. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy. This exclusion does not apply to benefits specifically provided in Benefits for Gender Affirming Treatment.
33. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
34. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
35. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the benefits for Preventive Care Services.

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

In the event of Injury or Sickness, students should:

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

If submitting a claim by mail, send the above information to the Company at:

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

Section 14: General Provisions

GRACE PERIOD: A grace period of 10 days for monthly premium policies and 31 days for all other policies will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

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.

CLAIM FORMS: Claim forms are not required.

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

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

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by the Policy may, at the Company's option, be paid directly to the Hospital or person rendering such service, unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss.

Indemnities provided under the Policy for any of the Out-of-Network Provider services listed in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* will be paid directly to the Provider.

Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization.

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

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

of the amount necessary to fully compensate the Insured for all expenses incurred as a result of his loss. The Insured shall be permitted to recoup his general damages, which is not limited to medical expenses, from the tort-feasor before subrogation provided that in so doing, the Insured does not prejudice the rights of the Company.

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

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

Section 15: Complaint Resolution

Insured Persons and Providers or their representatives may call the Customer Service Department at 800-767-0700 with questions or a Grievance. If the question or Grievance is not resolved to the satisfaction of the complainant, the complainant must submit, to the Company, a written request for resolution to the Grievance. A thorough investigation will be made and the Company will respond with a resolution within 45 business days. The Company will not retaliate against the complainant because of the Grievance.

“Grievance” means a complaint submitted by or on behalf of an Insured Person regarding service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the Company.

The resolution to the Grievance is not considered an Adverse Determination. If the complaint is the result of an adverse benefit determination, the Insured Person has the right to request a separate internal review of the Adverse Determination.

Section 16: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company’s denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person’s Authorized Representative, must submit an oral or written request for an Internal Appeal within 180 days of receiving a notice of the Company’s Adverse Determination. The Company will acknowledge receipt of the request for an Internal Appeal. An oral request shall be reduced to writing by the Company and a copy will be forwarded to the Insured Person, or the Insured Person’s Authorized Representative.

If submitting a written request for an Internal Appeal, the 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.

The right to request an Internal Appeal is accessible to an Insured Person who has a physical or mental disability, literacy issues or is a limited-English speaker. Please contact the Customer Service Department at 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process

Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination. If the request for review is related to services the Insured Person is currently receiving, a course of treatment which is Medically Necessary, or receiving as an Inpatient, those services will continue until the Insured Person has been notified of the final determination. If the Company upholds the Adverse Benefit Determination, the Insured Person may be responsible for the cost of these continued services.

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

Within 72 hours after receipt of the review request, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

1. Any new or additional evidence considered by the Company in connection with the review request; and
2. Any new or additional rationale upon which the decision was based.

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

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative within 14 days of receipt of the request for review, unless the Adverse Benefit Determination involves an experimental or investigational treatment. In the case of an Adverse Benefit Determination involving an experimental or investigational treatment, the Company will issue Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative within 20 days of receipt of the request for review.

The Company may extend the time it takes to issue a Final Adverse Decision, with good cause, by up to 16 additional days without the Insured's written consent and will notify the Insured Person or the Authorized Representative if the extension and reason for the extension. If further time is necessary for the Company to issue a Final Adverse Decision after the first extension, the Company must request the Insured Person's consent. The further extension request will be reduced to writing and will include a specific agreed upon date for determination.

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

The written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the review request, including the following:
 - a. The date of service;
 - b. The name health care provider; and
 - c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
 - a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
 - b. Reference to the specific Policy provisions upon which the determination is based;
 - c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
 - d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
 - e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
 - f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and

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

Expedited Internal Review

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

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

1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

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

Expedited Internal Review Process

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

1. Involving Urgent Care Requests; and
2. Related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility.

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

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

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The notice of Final Adverse Determination shall be provided orally, followed by a notice provided either in writing, or electronically.

RIGHT TO EXTERNAL INDEPENDENT REVIEW

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

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 180 days to request an External Independent Review.

Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Company. Upon request of an External Review, the Company shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review. If the request for review is related to a services the Insured Person is currently receiving a course of treatment which is Medically Necessary or is receiving as an Inpatient, those services will continue until the Insured Person has been notified of the final determination.

Where to Send External Review Requests

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

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

Standard External Review (SER) Process

A Standard External Review request must be submitted in writing within 180 days of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

1. After receiving a request for External Review, the Company shall, within 1 business day:
 - a. Refer the case to an Independent Review Organization (IRO) using the rotational registry system of certified IRO's established by the Commissioner;
 - b. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
2.
 - a. The Company shall, within 3 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
3. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
4. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
 - b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
 - c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
5. Within 15 days after receiving necessary information or within 20 days after receipt of the SER request, whichever is earlier, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

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

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Company at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
 - The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or

- b. A Final Adverse Determination, if:
 - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received Emergency Services, but has not been discharged from a facility.

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

2. After receiving a request for an EER, the Company shall immediately refer the case to an Independent Review Organization (IRO) using the rotational registry system of certified IRO's established by the Commissioner.
 - a. The Company shall immediately provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
 - b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
3.
 - a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's review request remains unresolved at the end of the EIR process.
4. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
 - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
 - b. Notify the Company, the Insured Person, and, if applicable, the Authorized Representative.
5. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

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

APPEAL RIGHTS DEFINITIONS

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

Adverse Determination means:

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

Authorized Representative means:

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

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

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

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

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

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
2. In the opinion of a physician with knowledge of the Insured Person's medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

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

Questions Regarding Appeal Rights

Contact Customer Service at 1-800-767-0700 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:

Office of the Washington State Insurance Commissioner
Consumer Protection Division
PO BOX 40256
Olympia, WA 98504-0256
(800) 562-6900
<https://www.insurance.wa.gov/your-insurance/health-insurance/appeal/>

Section 17: Online Access to Account Information

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

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

My Account now includes a message center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. 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 Profile and making the change there.

Section 18: ID Cards

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

Section 19: UHCSR Mobile App

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

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

Section 20: Important Company Contact Information

The Policy is Underwritten by:

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-800-767-0700

Website: www.uhcsr.com

Sales/Marketing Services:

UnitedHealthcare **Student**Resources

805 Executive Center Drive West, Suite 220

St. Petersburg, FL 33702

Email: info@uhcsr.com

Customer Service:

800-767-0700

(Customer Services Representatives are available Monday - Friday, 7:00 a.m. – 7:00 p.m. (Central Time))

A list of health care benefit managers utilized by UnitedHealthcare Insurance Company can be accessed at www.myuhc.com.

Section 21: Pediatric Dental Services Benefits

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

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

Insured Persons must always check the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. The Insured Person can check the participation status by calling the Company and/or the provider. The Company can help in referring the Insured Person to Network Dental Providers.

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

Non-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services 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. Insured Persons may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. When the Insured Person obtains Covered Dental Services from non-Network Dental Providers, the Insured Person must file a claim with the Company to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

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

Section 2: Benefits for Pediatric Dental Services

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

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

Network Benefits:

Benefits for Allowed Dental Amounts are determined as a percentage of the negotiated contract fee between the Company and the provider rather than a percentage of the provider's billed charge. The Company's negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge the Insured Person or the Company for any service or supply that is not Necessary as determined by the Company. If the Insured Person agrees to receive a service or supply that is not Necessary the Network provider may charge the Insured Person. However, these charges will not be considered Covered Dental Services and benefits will not be payable.

Non-Network Benefits:

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

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

Diagnostic Services (Preventive and Diagnostic)

- Clinical oral evaluations:
 - Comprehensive oral evaluation including:
 - Complete dental/medical history and general health assessment;
 - Complete thorough evaluation of extra-oral and intra-oral hard and soft tissue;
 - The evaluation and recording of dental caries, missing or unerupted teeth restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies and oral cancer screening;
 - Periodic oral evaluation – subsequent thorough evaluation of an established patient to determine the need for sealants, fluoride and/or treatment setting;
 - Oral evaluation for patient under the age of 3 and counseling with primary caregiver;
 - Limited oral evaluations that are problem focused; and
 - Detailed oral evaluations that are problem focused.
- Diagnostic Imaging with interpretation:
 - A full mouth series;
 - An extraoral panoramic film;
 - Bitewings, periapicals, panoramic and cephalometric radiographic images;
 - Intraoral and extraoral radiographic images;
 - Oral/facial photographic images;
 - Maxillofacial MRI, ultrasound; and
 - X-rays not listed above, on a case-by-case basis, when Medically Necessary.
- Tests and Examinations, including one pulp vitality test per visit.
- Viral culture.
- Collection and preparation of saliva sample for laboratory diagnostic testing.
- Diagnostic casts – for diagnostic purposes only and not in conjunction with other services.
- Oral pathology laboratory:
 - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report;
 - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report;
 - Other oral pathology procedures, by report.

Preventive Services (Preventive and Diagnostic)

- Dental prophylaxis.
- Topical fluoride treatment, including fluoride rinse, foam or gel, including disposable trays for the treatment.
- Fluoride varnish.
- Sealants.
- Oral hygiene instruction, including individualized oral hygiene instructions, tooth brushing techniques, flossing and use of oral hygiene aids, every 12 months for ages 8 and under, only if not billed on the same day with dental prophylaxis.
- Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal:
 - Fixed – unilateral and bilateral;
 - Removable – bilateral only;
 - Recementation of fixed space maintainer;

- Removal of fixed space maintainer – considered for provider that did not place appliance.

Restorative Services (Basic)

- Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
- Gold foil - Service includes local anesthesia, polishing and adjusting occlusion.

Adjunctive General Services (Basic)

- Palliative treatment for emergency treatment – per visit.
- Anesthesia:
 - Local anesthesia NOT in conjunction with operative or surgical procedures;
 - Regional block;
 - Trigeminal division block;
 - Deep sedation/general anesthesia;
 - Intravenous conscious sedation/analgesia;
 - Nitrous oxide/analgesia;
 - Non-intravenous conscious sedation; and
 - Office visit for observation – (during regular hours) no other service performed.
- Drugs:
 - Therapeutic parenteral drug;
 - Single administration; and
 - Two or more administrations – not to be combined with single administration.
 - Other drugs and/or medicaments – by report.
- Application of desensitizing medicament – per visit.
- Occlusal guard – for treatment of bruxism, clenching or grinding.
- Athletic mouthguard covered once per year.
- Occlusal adjustment.
- Odontoplasty.
- General Services (including Emergency Treatment, behavior management, 2 house/extended care facility calls, 1 hospital call, and treatment of post-surgical complications as described in Section 1: Covered Health Services under Physician's Office Services - Sickness and Injury).

Endodontic Services (Basic)

- Therapeutic pulpotomy for primary and permanent teeth.
- Pulpal debridement for primary and permanent teeth.
- Partial pulpotomy for apexogenesis.
- Pulpal therapy for anterior and posterior primary teeth.
- Endodontic therapy and retreatment.
- Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation.
- Apexification: initial, interim and final visits.
- Pulpal regeneration.
- Apicoectomy/Periradicular Surgery.
- Retrograde filling.
- Root amputation.
- Surgical procedure for isolation of tooth with rubber dam.
- Hemisection.
- Canal preparation and fitting of preformed dowel or post.
- Post removal.

Oral Surgery and Maxillofacial Surgical Services (Basic)

- Extraction of teeth:
 - Extraction of coronal remnants – deciduous tooth;
 - Extraction, erupted tooth or exposed root;
 - Surgical removal of erupted tooth or residual root;
 - Impactions: removal of soft tissue, partially bony, completely bony and completely bony with unusual surgical complications.
- Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.

- Other surgical Procedures:
 - Oroantral fistula;
 - Primary closure of sinus perforation and sinus repairs;
 - Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident;
 - Surgical access of an unerupted tooth;
 - Mobilization of erupted or malpositioned tooth to aid eruption;
 - Placement of device to aid eruption;
 - Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy;
 - Surgical repositioning of tooth/teeth;
 - Transseptal fiberotomy/supra crestal fiberotomy;
 - Surgical placement of anchorage device with or without flap; and
 - Harvesting bone for use in graft(s).
- Alveoloplasty in conjunction or not in conjunction with extractions.
- Vestibuloplasty.
- Excision of benign and malignant tumors/lesions.
- Removal of cysts (odontogenic and nonodontogenic) and foreign bodies.
- Destruction of lesions by electrosurgery.
- Removal of lateral exostosis, torus palatinus or torus mandibularis.
- Surgical reduction of osseous tuberosity.
- Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
- Surgical Incision:
 - Incision and drainage of abscess - intraoral and extraoral;
 - Removal of foreign body;
 - Partial ostectomy/sequestrectomy; and
 - Maxillary sinusotomy.
- Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
- Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage.
- Arthroscopy.
- Occlusal orthotic device – includes placement and removal to same provider.
- Surgical and other repairs:
 - Skin and bone graft and synthetic graft;
 - Collection and application of autologous blood concentrate;
 - Osteoplasty and osteotomy;
 - LeFort I, II, III with or without bone graft;
 - Graft of the mandible or maxilla – autogenous or nonautogenous;
 - Frenectomy and frenoplasty;
 - Excision of hyperplastic tissue and pericoronal gingiva;
 - Appliance removal – "by report" for provider that did not place appliance, splint or hardware.

Periodontal Services (Basic)

- Surgical services:
 - Gingivectomy and gingivoplasty;
 - Gingival flap including root planning;
 - Apically positioned flap;
 - Clinical crown lengthening;
 - Osseous surgery;
 - Bone replacement graft – first site and additional sites;
 - Biologic materials to aid soft and osseous tissue regeneration;
 - Guided tissue regeneration;
 - Surgical revision;
 - Pedicle and free soft tissue graft;
 - Subepithelial connective tissue graft;
 - Distal or proximal wedge;
 - Soft tissue allograft; and
 - Combined connective tissue and double pedicle graft.
- Non-Surgical Periodontal Service:
 - Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma;
 - Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs;
 - Full mouth debridement to enable comprehensive evaluation; and

- Localized delivery of antimicrobial agents.
- Periodontal maintenance.

Crowns – (Major)

- Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program.
- Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
- Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown.
- Prefabricated stainless steel, stainless steel crown with resin window and resin crowns.
- Retreatment for the removal of post, pin, or old root canal filling material.
- Core buildup, including pins.
- Pin retention.
- Indirectly fabricated (custom fabricated/cast) and prefabricated post and core.
- Additional fabricated (custom fabricated/cast) and prefabricated post.
- Post removal.
- Temporary crown (fractured tooth).
- Additional procedures to construct new crown under existing partial denture.
- Coping.
- Crown repair.
- Protective restoration/sedative filling.

Prosthodontic Services (Major)

- Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies.
- Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic):
 - Resin base and cast frame dentures including any conventional clasps, rests and teeth;
 - Flexible base denture including any clasps, rests and teeth; and
 - Removable unilateral partial dentures or dentures without clasps are not considered.
- Overdenture – complete and partial.
- Denture adjustments – 6 months after insertion or repair.
- Denture repairs – includes adjustments for first 6 months following service.
- Denture rebase denture rebase is covered and includes adjustments for first 6 months following service.
- Denture relines – includes adjustments for first 6 months following service.
- Precision attachment, by report.
- Fixed and Partial Dentures.
- Maxillofacial prosthetics - includes adjustments for first 6 months following service:
 - Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement;
 - Obturator prosthesis: surgical, definitive and modifications;
 - Mandibular resection prosthesis with and without guide flange;
 - Surgical stents;
 - Radiation carrier;
 - Topical medicament carrier;
 - Adjustments, modification and repair to a maxillofacial prosthesis;
 - Maintenance and cleaning of maxillofacial prosthesis.

Implant Services (Major)

- Covered services include: implant body, abutment and crown.
- Implant – mandibular augmentation purposes.

Medically Necessary Orthodontic Services (Major)

Orthodontic Treatment requires prior authorization and is not considered for cosmetic purposes. Treatment must meet all criteria of Medical Necessity. Coverage includes:

- Limited treatment for the primary, transitional.
- Interceptive treatment for the primary and transitional dentition.
- Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate Medical Necessity.

- Orthognathic Surgical Cases with comprehensive orthodontic treatment.
- Repairs to orthodontic appliances.
- Replacement of lost or broken retainer.
- Rebonding or recementing of brackets and/or bands.

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
Diagnostic Services		
<i>Evaluations (Checkup Exams)</i> Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation D0180 - Comprehensive periodontal evaluation The following service is not subject to a frequency limit. D0160 - Detailed and extensive oral evaluation - problem focused	75%	75%
<i>Intraoral Radiographs (X-ray)</i> Limited to 2 series of films per 12 months. D0210 - Complete series (including bitewings) D0709 - Intraoral - complete series of radiographic images - image capture only	75%	75%
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0240 - Intraoral - occlusal film D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings D0708 - Intraoral - bitewing radiographic image - image capture only	75%	75%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only D0704 - 3-D Photographic image - image capture only	75%	75%
The following services are limited to 2 images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	75%	75%
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0391 - Interpretation of diagnostic images D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	75%	75%
Preventive Services		
<i>Dental Prophylaxis (Cleanings)</i> <i>The following services are limited to 2 times every 12 months.</i> D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	75%	75%
<i>Fluoride Treatments</i> <i>The following services are limited to 3 times every 12 months.</i> D1206 and D1208 - Fluoride	75%	75%
<i>Sealants (Protective Coating)</i>	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
<p><i>The following services are limited to once per bicuspid and first or second permanent molar every 24 months.</i></p> <p>D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth</p>		
<p><i>Space Maintainers (Spacers)</i></p> <p>The following services are not subject to a frequency limit and includes replacement of space maintainers when Necessary.</p> <p>D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant</p>	75%	75%
Minor Restorative Services		
<p><i>Amalgam Restorations (Silver Fillings)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent</p>	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior</p>	75%	75%
Crowns/Inlays/Onlays		
<p>The following services are subject to a limit of 1 time every 60 months.</p> <p>D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four surfaces D2740 - Crown - porcelain/ceramic substrate D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth</p> <p>The following services are not subject to a frequency limit.</p> <p>D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces</p>	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D2530 - Inlay - metallic - three surfaces D2910 - Re-cement inlay D2920 - Re-cement crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	75%	75%
The following services are limited to 1 time per tooth every 60 months. D2929 - Prefabricated porcelain crown - primary D2950 - Core buildup, including any pins	75%	75%
The following service is limited to 1 time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to crown	75%	75%
<i>The following service is not subject to a frequency limit.</i> D2954 - Prefabricated post and core in addition to crown	75%	75%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair D2982 - Onlay repair D2983 - Veneer repair D2990 - Resin infiltration/smooth surface	75%	75%
Endodontics		
<i>The following service is not subject to a frequency limit.</i> D3220 - Therapeutic pulpotomy (excluding final restoration)	75%	75%
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	75%	75%
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
<p>The following services are not subject to a frequency limit.</p> <p>D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar</p>	75%	75%
<p>The following services are not subject to a frequency limit.</p> <p>D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification - interim medication replacement D3353 - Apexification/recalcification - final visit</p>	75%	75%
<p>The following service is not subject to a frequency limit.</p> <p>D3354 - Pulpal regeneration</p>	75%	75%
<p>The following services are not subject to a frequency limit.</p> <p>D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar</p>	75%	75%
<p>The following service is not subject to a frequency limit.</p> <p>D3450 - Root amputation - per root</p>	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
<p>The following service is not subject to a frequency limit.</p> <p>D3920 - Hemisection (including any root removal), not including root canal therapy</p>	75%	75%
Periodontics		
<p>The following services are limited to a frequency of 1 every 36 months.</p> <p>D4210 - Gingivectomy or gingivoplasty - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three teeth D4212 - Gingivectomy or gingivoplasty - with restorative procedures - per tooth</p>	75%	75%
<p>The following services are limited to 1 every 36 months.</p> <p>D4240 - Gingival flap procedure, four or more teeth D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant</p>	75%	75%
<p>The following service is not subject to a frequency limit.</p> <p>D4249 - Clinical crown lengthening - hard tissue</p>	75%	75%
<p>The following services are limited to 1 every 36 months.</p> <p>D4260 - Osseous surgery D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft - first site in quadrant</p>	75%	75%
<p>The following services are not subject to a frequency limit.</p> <p>D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure</p>	75%	75%
<p>The following services are not subject to a frequency limit.</p> <p>D4273 - Subepithelial connective tissue graft procedures, per tooth D4275 - Soft tissue allograft D4277 - Free soft tissue graft - first tooth</p>	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D4278 - Free soft tissue graft - additional teeth		
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	75%	75%
The following service is limited to a frequency to 1 per every 3 years. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	75%	75%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	75%	75%
Removable Dentures		
The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5510 - Repair broken complete denture base D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5620 - Repair cast framework	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture		
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)	75%	75%
The following services are not subject to a frequency limit. D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	75%	75%
Bridges (Fixed partial dentures)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic		
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	75%	75%
The following services are not subject to a frequency limit. D6519 - Inlay/onlay - porcelain/ceramic D6520 - Inlay - metallic - two surfaces D6530 - Inlay - metallic - three or more surfaces D6543 - Onlay - metallic - three surfaces D6544 - Onlay - metallic - four or more surfaces	75%	75%
The following services are limited to 1 time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D6792 - Retainer crown - full cast noble metal		
The following service is not subject to a frequency limit.	75%	75%
D6930 - Re-cement or re-bond fixed partial denture		
The following services are not subject to a frequency limit.	75%	75%
D6973 - Core build up for retainer, including any pins D6980 - Fixed partial denture repair necessitated by restorative material failure		
Oral Surgery		
The following service is not subject to a frequency limit.	75%	75%
D7140 - Extraction, erupted tooth or exposed root		
The following services are not subject to a frequency limit.	75%	75%
D7210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal		
The following service is not subject to a frequency limit.	75%	75%
D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth		
The following service is not subject to a frequency limit.	75%	75%
D7280 - Surgical access of an unerupted tooth		
The following services are not subject to a frequency limit.	75%	75%
D7310 - Alveoloplasty in conjunction with extractions - per quadrant		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant		
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	75%	75%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess D7910 - Suture of recent small wounds up to 5 cm D7921 - Collect - apply autologous product D7953 - Bone replacement graft for ridge preservation - per site D7960 - Frenulectomy - also known as Frenectomy or Frenotomy - separate procedure not incidental to another procedure D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7963 - Frenuloplasty D7971 - Excision of pericoronal gingiva	75%	75%
Adjunctive Services		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure	75%	75%
Covered only when clinically Necessary. D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D9222 - Deep sedation/general anesthesia - first 15 minutes D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9610 - Therapeutic drug injection, by report		
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	75%	75%
The following is limited to 1 guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch	75%	75%
Implant Procedures		
The following services are limited to 1 time every 60 months. D6010 - Endosteal implant D6012 - Surgical placement of interim implant body D6040 - Eposteal implant D6050 - Transosteal implant, including hardware D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported D6056 - Prefabricated abutment D6057 - Custom abutment D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to high noble metal D6060 - Abutment supported porcelain fused to predominately base metal crown D6061 - Abutment supported porcelain fused to noble metal crown D6062 - Abutment supported cast high noble metal crown	75%	75%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D6063 - Abutment supported cast predominately base metal crown D6064 - Abutment supported porcelain/ceramic crown D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture D6072 - Abutment supported retainer for cast high noble metal fixed partial denture D6073 - Abutment supported retainer for predominately base metal fixed partial denture D6074 - Abutment supported retainer for cast metal fixed partial denture D6075 - Implant supported retainer for ceramic fixed partial denture D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant prosthesis D6091 - Replacement of replaceable part of semi-precision or precision attachment D6095 - Repair implant abutment D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Implant removal D6101 - Debridement peri-implant defect D6102 - Debridement and osseous peri-implant defect D6103 - Bone graft peri-implant defect D6104 - Bone graft implant replacement D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 - Implant index D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		
Medically Necessary Orthodontics		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy, medical conditions as indicated on the Washington Modified Handicapping Labiolingual Deviation (HDL) Index Score that result in a		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
<p>score of 25 or higher, or other severe craniofacial deformities, including but not limited to, hemifacial macrosomia, craniosynostosis syndromes, Arthrogryposis, and Marfan syndrome, which result in a physically handicapping malocclusion as determined by the Company's dental consultants. The Company reviews all requests for treatment for conditions that result in a score of less than 25 on a case-by-case basis, with consideration of Medical Necessity. 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.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.</p>		
<p>The following services are not subject to a frequency limitation as long as benefits have been prior authorized.</p> <p>D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8050 - Interceptive orthodontic treatment of the primary dentition D8060 - Interceptive orthodontic treatment of the transitional dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular</p>	75%	75%

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 Service or Procedure not listed as a Covered Dental Service in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
9. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
17. Services rendered by a provider who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

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

Allowed Dental Amounts - Allowed Dental Amounts 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, Allowed Dental Amounts 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, Allowed Dental Amounts are the Usual and Customary Fees, as defined below.

Covered Dental Service - a Dental Service or Dental Procedure for which benefits are provided under this Pediatric Dental benefits provision.

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

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

Experimental, Investigational, or Unproven Service - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

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

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - For treating a life threatening dental disease or condition.
 - Provided in a clinically controlled research setting.
 - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined. The definition of Necessary used relates only to benefits under this provision and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

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

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

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

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

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

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

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

Section 22: Pediatric Vision Services Benefits

Benefits are provided for Vision Care Services, as described below, 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 UnitedHealthcare Vision Network or non-Network Vision Care Provider. To find a UnitedHealthcare Vision Network 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 UnitedHealthcare Vision Network Vision Care Providers on the Internet at www.myuhcvision.com.

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

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

Network Benefits:

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

Non-Network Benefits:

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

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

Policy Deductible

Benefits for pediatric Vision Care Services provided 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*.

What Are the Benefit Descriptions?

Benefits

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

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

Frequency of Service Limits

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

Routine Vision Examination

A routine vision examination of the eyes and according to the standards of care in the area where the Insured Person resides, including:

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) – helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation – how well the Insured Person sees up close (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the inside of the eye.

- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.
- Dilation as professionally indicated, including refraction.

Post exam 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 placed in eyeglass frames and worn on the face to correct visual acuity limitations.

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

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

Eyeglass Frames

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

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

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

Contact Lenses

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

Benefits include the fitting/evaluation fees, contact lenses, and follow-up care.

The Insured Person is eligible to choose 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 Insured Persons who have severe visual problems that cannot be corrected 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.

Benefits include:

- 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, and any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.
- Low vision aids: Prescribed Medically Necessary optical devices, such as high-power spectacles, magnifiers, and telescopes.
- Low vision follow-up care of four visits in any five year period.

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%	100% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100%	100% of the billed charge.
• Bifocal		100%	100% of the billed charge.
• Trifocal		100%	100% of the billed charge.
• Lenticular		100%	100% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	100% of the billed charge.
• Eyeglass frames with a retail cost of \$131 - 160.		100%	100% of the billed charge.
• Eyeglass frames with a retail cost of \$161 - 200.		100%	100% of the billed charge.
• Eyeglass frames with a retail cost of \$201 - 400.		100%	100% of the billed charge.
• Eyeglass frames with a retail cost greater than \$401.		50%	100% of the billed charge.

Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100%	100% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100%	100% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Vision Care Service Low Vision Care Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low vision testing		100% of the billed charge.	75% of the billed charge.
• Low vision therapy		100% of the billed charge.	75% of the billed charge.
• Low vision aids		100% of the billed charge.	75% of the billed charge.
• Low vision follow-up care	Four visits in any 5 year period	100% of the billed charge.	75% 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. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services*.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):
248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

UnitedHealthcare Vision Network - 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 23: Assistance and Evacuation Benefits

An Insured Person under this insurance plan is eligible for Assistance and Evacuation Benefits in addition to the underlying plan coverage. The requirements to receive these benefits are as follows:

International Students, insured spouse or Domestic Partner and insured minor child(ren) are eligible to receive Assistance and Evacuation Benefits worldwide, except in their Home Country.

DEFINITIONS

The following definitions apply to the Assistance and Evacuation Benefits described further below.

“Emergency Medical Event” means an event wherein an Insured Person’s medical condition and situation are such that, in the opinion of the Company’s affiliate or authorized vendor and the Insured Person’s treating physician, the Insured Person requires urgent medical attention without which there would be a significant risk of death, or serious impairment and adequate medical treatment is not available at the Insured Person’s initial medical facility.

“Home Country” means, with respect to an Insured Person, the country or territory as shown on the Insured Person’s passport or the country or territory of which the Insured Person is a permanent resident.

“Host Country” means, with respect to an Insured Person, the country or territory the Insured Person is visiting or in which the Insured Person is living, which is not the Insured Person’s Home Country.

“Physician Advisors” mean physicians retained by the Company’s affiliate or authorized vendor for provision of consultative and advisory services to the Company’s affiliate or authorized vendor, including the review and analysis of the medical care received by Insured Persons.

An Insured Person must notify the Company’s affiliate or authorized vendor to obtain benefits for Medical Evacuation and Repatriation. If the Insured Person doesn’t notify the Company’s affiliate or authorized vendor, the Insured Person will be responsible for paying all charges and no benefits will be paid.

MEDICAL EVACUATION AND REPATRIATION BENEFITS

Emergency Medical Evacuation: If an Insured Person suffers a Sickness or Injury, experiences an Emergency Medical Event and adequate medical facilities are not available locally in the opinion of the Medical Director of the Company’s affiliate or authorized vendor, the Company’s affiliate or authorized vendor will provide an emergency medical evacuation (under medical supervision if necessary) to the nearest facility capable of providing adequate care by whatever means is necessary. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the emergency medical evacuation.

Dispatch of Doctors/Specialists: If an Insured Person experiences an Emergency Medical Event and the Company’s affiliate or authorized vendor determines that an Insured Person cannot be adequately assessed by telephone for possible medical evacuation from the initial medical facility or that the Insured Person cannot be moved and local treatment is unavailable, the Company’s affiliate or authorized vendor will arrange to send an appropriate medical practitioner to the Insured Person’s location when it deems it appropriate for medical management of a case. The Company will pay costs for

transportation and expenses associated with dispatching a medical practitioner to an Insured Person's location, not including the costs of the medical practitioner's service.

Medical Repatriation: After an Insured Person receives initial treatment and stabilization for a Sickness or Injury, if the attending physician and the Medical Director of the Company's affiliate or authorized vendor determine that it is medically necessary, the Company's affiliate or authorized vendor will transport an Insured Person back to the Insured Person's permanent place of residence for further medical treatment or to recover. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Transportation after Stabilization: If Medical Repatriation is not required following stabilization of the Insured Person's condition and discharge from the hospital, the Company's affiliate or authorized vendor will coordinate transportation to the Insured Person's point of origin, Home Country, or Host Country. The Company will pay costs for economy transportation (or upgraded transportation to match an Insured Person's originally booked travel arrangements) to the Insured Person's original point of origin, Home Country or Host Country.

Transportation to Join a Hospitalized Insured Person: If an Insured Person who is travelling alone is or will be hospitalized for more than three (3) days due to a Sickness or Injury, the Company's affiliate or authorized vendor will coordinate round-trip airfare for a person of the Insured Person's choice to join the Insured Person. The Company will pay costs for economy class round-trip airfare for a person to join the Insured Person.

Return of Minor Children: If an Insured Person's minor child(ren) age 18 or under are present but left unattended as a result of the Insured Person's Injury or Sickness, the Company's affiliate or authorized vendor will coordinate airfare to send them back to the Insured Person's Home Country. The Company's affiliate or authorized vendor will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required as determined by the Company's affiliate or authorized vendor. The Company will pay costs for economy class one-way airfare for the minor children (or upgraded transportation to match the Insured Person's originally booked travel arrangement) and, if required, the cost of the services, transportation expenses, and accommodations of a non-medical escort to accompany the minor children back to the Insured Person's Home Country.

Repatriation of Mortal Remains: In the event of an Insured Person's death, the Company's affiliate or authorized vendor will assist in obtaining the necessary clearances for the Insured Person's cremation or the return of the Insured Person's mortal remains. The Company's affiliate or authorized vendor will coordinate the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. The Company will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence.

CONDITIONS AND LIMITATIONS

Assistance and Evacuation Benefits shall only be provided to an Insured Person after the Company's affiliate or authorized vendor receives the request (in writing or via phone) from the Insured Person or an authorized representative of the Insured Person of the need for the requested Assistance and Evacuation Benefits. In all cases, the requested Assistance and Evacuation Benefits services and payments must be arranged, authorized, verified and approved in advance by the Company's affiliate or authorized vendor.

With respect to any evacuation requested by an Insured Person, the Company's affiliate or authorized vendor reserves the right to determine, at its sole discretion, the need for and the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician Advisors and treating physicians as needed to make its determination.

In the event an Insured Person is incapacitated or deceased, his/her designated or legal representative shall have the right to act for and on behalf of the Insured Person.

The following Exclusions and Limitations apply to the Assistance and Evacuation Benefits.

In no event shall the Company be responsible for providing Assistance and Evacuation Benefits to an Insured Person in a situation arising from or in connection with any of the following:

1. Travel costs that were neither arranged nor approved in advance by the Company's affiliate or authorized vendor.

2. Taking part in military or police service operations.
3. Insured Person's failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
4. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.
5. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
7. Medical Evacuations directly or indirectly related to a natural disaster.
8. Subsequent Medical Evacuations for the same or related Sickness, Injury or Emergency Medical Event regardless of location.

Additional Assistance Services

The following assistance services will be available to an Insured Person in addition to the Assistance and Evacuation Benefits.

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: Upon an Insured Person's request, the Company's affiliate or authorized vendor will provide referrals to physicians, hospitals, dentists, and dental clinics in the area the Insured Person is traveling in order to assist the Insured Person in locating appropriate treatment and quality care.

Monitoring of Treatment: As and to the extent permissible, the Company's affiliate or authorized vendor will continually monitor the Insured Person's medical condition. Third-party medical providers may offer consultative and advisory services to the Company's affiliate or authorized vendor in relation to the Insured Person's medical condition, including review and analysis of the quality of medical care received by the Insured Person.

Facilitation of Hospital Admittance Payments: The Company's affiliate or authorized vendor will issue a financial guarantee (or wire funds) on behalf of Company up to five thousand dollars (US\$5,000) to facilitate admittance to a foreign (non-US) medical facility.

Relay of Insurance and Medical Information: Upon an Insured Person's request and authorization, the Company's affiliate or authorized vendor will relay the Insured Person's insurance benefit information and/or medical records and information to a health care provider or treating physician, as appropriate and permissible, to help prevent delays or denials of medical care. The Company's affiliate or authorized vendor will also assist with hospital admission and discharge planning.

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, the Company's affiliate or authorized vendor will coordinate the transfer of the medication or vaccine to Insured Persons upon the prescribing physician's authorization, if it is legally permissible.

Updates to Family, Employer, and Home Physician: Upon an Insured Person's approval, the Company's affiliate or authorized vendor will provide periodic case updates to appropriate individuals designated by the Insured Person in order to keep them informed.

Hotel Arrangements: The Company's affiliate or authorized vendor will assist Insured Persons with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

Replacement of Corrective Lenses and Medical Devices: The Company's affiliate or authorized vendor will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, an Insured Person can contact the Company's affiliate or authorized vendor to have a pre-trip destination report sent to the Insured Person. This report draws upon an intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime, emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. The global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: The Company's affiliate or authorized vendor will assist the Insured Person in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: The Company's affiliate or authorized vendor will make new reservations for airlines, hotels, and other travel services for an Insured Person in the event of a Sickness or Injury, to the extent that the Insured Person is entitled to receive Assistance and Evacuation Benefits.

Transfer of Funds: The Company's affiliate or authorized vendor will provide the Insured Person with an emergency cash advance subject to the Company's affiliate or authorized vendor first securing funds from the Insured Person (via a credit card) or his/her family.

Legal Referrals: Should an Insured Person require legal assistance, the Company's affiliate or authorized vendor will direct the Insured Person to a duly licensed attorney in or around the area where the Insured Person is located.

Language Services: The Company's affiliate or authorized vendor will provide immediate interpretation assistance to an Insured Person in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, the Company's affiliate or authorized vendor will provide the Insured Person with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

Message Transmittals: Insured Persons may send and receive emergency messages toll-free, 24-hours a day, through the Company's affiliate or authorized vendor.

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

Assistance and Evacuation Services are available 24 hours a day, 7 days a week, 365 days a year.

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at www.uhcsr.com/MyAccount and select My Benefits/Additional Benefits/UHC Global Emergency Services.

When calling the Emergency Response Center, the caller should be prepared to provide the following information:

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

If the condition is a medical emergency, the Insured Person should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to the Company for consideration at the address located in the "How to File a Claim for Injury and Sickness Benefits" section of the Certificate of Coverage and are subject to all Policy benefits, provisions, limitations, and exclusions.

Section 24: Highlights of Services Included with the Student Injury and Sickness Insurance Plan

Healthiest You: 24/7 Doctor Access

Starting on the effective date of your coverage under the student insurance plan, you have 24/7 access to medical advice through HealthiestYou, a national telehealth service*. By visiting www.telehealth4students.com, you have access to board-certified physicians via phone and/or video, where permitted. This service is especially helpful for minor illnesses, such as allergies, sore throat, earache, pink eye, etc. Based on the condition being treated, the doctor can also prescribe certain medications, saving you a trip to the doctor's office. Using HealthiestYou can save you money and time, while avoiding costly trips to a doctor's office, urgent care facility, or emergency room. As an insured with **StudentResources**, there is no consultation fee for this service. * Every call with a HealthiestYou doctor is covered 100% during your policy period. You can learn more about this benefit and how to use it in My Account.

This service is meant to complement your Student Health Center. If possible, we encourage you to visit your SHC first before using this service.

HealthiestYou is not health insurance. HealthiestYou is designed to complement, and not replace, the care you receive from your primary care physician. HealthiestYou physicians are an independent network of doctors who advise, diagnose, and prescribe at their own discretion. HealthiestYou physicians provide cross coverage and operate subject to state regulations. Physicians in the independent network do not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. HealthiestYou does not guarantee that a prescription will be written. Services may vary by state.

*Available to Insured students and their covered Dependents; age restrictions may apply. If you call prior to the effective date of your coverage under the insurance plan, you will be charged a service fee before being connected to a board-certified physician.

24/7 Student Assist

Insureds have immediate access to the Student Assistance Program, a service that coordinates care using a network of resources. Services available include:

- 24/7 Crisis Support – access to trained master's level specialists, 24/7/365, who provide in-the-moment support and consultation.
- Financial and Legal Advice - financial services are provided by licensed CPA's and Certified Financial Planners who offer consultations on issues such as financial planning, credit and collection issues, home buying and renting and more. Legal Services are provided by fully credentialed attorneys with at least 5 years of experience practicing law.
- Mediation services - available to help resolve family-related disputes, including but not limited to separation, child custody, child support, divorce property and debt division, etc.
- Living Well Portal – access to liveanworkwell.com where insureds can participate in personalized self-help programs and find information on many helpful resources.
- CollegeLife – direct access to experts on the Optum team and through referrals to a broad spectrum of pre-screened and qualified convenience resources.
- Sanvello – access to an evidence-based mobile care solution created by clinical experts that allows insureds to access on-demand help for stress, anxiety, and depression.

Translation services are available in over 170 languages for most services. More information about these services is available by logging into **My Account** at www.uhcsr.com/MyAccount under Additional Benefits.

Schedule of Benefits

Washington State University

2022-312-4

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 82.480%

Injury and Sickness Benefits

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

Deductible Preferred Provider	\$500 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	\$1,000 (per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	60% except as noted below
Out-of-Pocket Maximum	\$7,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum	\$14,000 (For all Insureds in a Family, Per Policy Year)

The Coinsurance amount is the percentage of Covered Medical Expenses that the Company pays. For the Covered Medical Expenses listed in the Schedule of Benefits, benefits will be paid at the Coinsurance amount stated above, unless otherwise specifically stated.

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

The **Provider** network for this plan is Choice.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider.

Out-of-Network Provider Benefits apply to Covered Medical Expenses that are provided by an Out-of-Network Provider. Refer to the *Preferred Provider and Out-of-Network Provider Information* section of the Certificate for information on reimbursement for Emergency Services provided by an Out-of-Network Provider, Covered Medical Expenses provided at certain Preferred Provider facilities by an Out-of-Network Physician, and Air Ambulance transport provided by an Out-of-Network Provider.

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

Student Health Center Benefits:

Benefits will be paid as specified below for services not covered by the student health fee when treatment is rendered at Cougar Health Services (CHS) on the Pullman campus, Multicare Rockwood Clinic for students attending the Spokane campus, and Community Health of Central Washington for students attending the Yakima campus. Multicare Rockwood Clinic in Spokane, Community Health of Central Washington in Yakima and CHS Vancouver Clinic in Vancouver serve as the CHS for students attending these campuses.

- All CHS locations: The Deductible and Copays will be waived for Covered Medical Expenses incurred when treatment is rendered at CHS.
- At CHS Pullman Campus location only: Benefits will be paid at 100% for Covered Medical Expenses subject to any benefit maximums, except as follows: 1) Outpatient Physiotherapy will be paid at 80% for Covered Medical Expenses; and 2) Prescription Drugs will be paid 80% for generic drugs and 70% for brand-name drugs up to a 90-day supply. Self-administrable injectable medications are limited to a 31-day supply, other than insulin.
- At Multicare Rockwood Clinic, Community Health of Central Washington and CHS Vancouver Clinic locations: Benefits will be paid at the Coinsurance and benefit maximums applicable to all other providers, except Outpatient Physiotherapy will be paid at 80% for Covered Medical Expenses incurred.
- Vision exams performed at CHS Pullman Campus will be covered at 100%.
- Chlamydia and Gonorrhea tests rendered at CHS Pullman Campus are covered at 100%, unless covered under the Preventive Care Services benefit.

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

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Intensive Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Miscellaneous Expenses	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Routine Newborn Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50%, per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50%, per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Registered Nurse's Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50%, per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Day Surgery Miscellaneous	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the amount paid for all subsequent procedures will be 50%, per procedure.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	\$25 Copay per visit 80% of Allowed Amount after Deductible	\$25 Copay per visit 60% of Allowed Amount after Deductible
Physiotherapy	80% of Allowed Amount	60% of Allowed Amount

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	after Deductible	after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	\$200 Copay per visit 100% of Allowed Amount after Deductible	\$200 Copay per visit 100% of Allowed Amount after Deductible
Diagnostic X-ray Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Radiation Therapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Laboratory Procedures	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Tests & Procedures	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Injections	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Chemotherapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Prescription Drugs The Policy does not include a pharmacy network for Prescription Drugs. All Prescription Drug benefits are payable as shown in the Out-of-Network Provider benefits. The Insured Person will be responsible for paying the lowest of either the applicable Coinsurance as provided in this benefit or the amount the Insured Person would pay for the Prescription Drug when purchased without using benefits provided under the Policy. No Deductible, Copays, or Coinsurance will be applied to contraceptives covered under the Preventive Care Services benefit. The total amount an Insured is required to pay for a covered insulin Prescription Drug will not exceed \$100 per 30-day supply. Insulin Prescription Drugs will be covered without being subject to a Deductible and any Copay and/or Coinsurance paid by the Insured will be applied toward the Insured's Deductible.	Not Applicable	80% Coinsurance per prescription generic drug 70% Coinsurance per prescription brand-name drug up to a 31-day supply per prescription after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Durable Medical Equipment	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Consultant Physician Fees	\$25 Copay per visit 80% of Allowed Amount after Deductible	\$25 Copay per visit 60% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Dental Injury \$300 maximum per Policy Year for each Injury	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Dental Treatment	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Mental Illness Treatment See Benefits for Mental Disorders and Substance Use Disorders	Inpatient: 80% of Allowed Amount after Deductible Outpatient office visits: \$25 Copay per visit 80% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible	Inpatient: 60% of Allowed Amount after Deductible Outpatient office visits: \$25 Copay per visit 60% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 60% of Allowed Amount after Deductible
Substance Use Disorder Treatment See Benefits for Mental Disorders and Substance Use Disorders	Inpatient: 80% of Allowed Amount after Deductible Outpatient office visits: \$25 Copay per visit 80% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 80% of Allowed Amount after Deductible	Inpatient: 60% of Allowed Amount after Deductible Outpatient office visits: \$25 Copay per visit 60% of Allowed Amount after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: 60% of Allowed Amount after Deductible
Maternity	80% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 80% of Allowed Amount for other covered services after Deductible	60% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 60% of Allowed Amount for other covered services after Deductible
Complications of Pregnancy	80% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 80% of Allowed Amount for other covered services after Deductible	60% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 60% of Allowed Amount for other covered services after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	100% of Allowed Amount
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Diabetes Services See Benefits for Diabetes	80% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 80% of Allowed Amount for other covered services after Deductible	60% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 60% of Allowed Amount for other covered services after Deductible
Home Health Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospice Care	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Inpatient Rehabilitation Facility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Skilled Nursing Facility 60 days maximum per Policy Year	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Urgent Care Center	\$25 Copay per visit 80% of Allowed Amount after Deductible	\$25 Copay per visit 60% of Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Approved Clinical Trials	80% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 80% of Allowed Amount for other covered services after Deductible	60% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 60% of Allowed Amount for other covered services after Deductible
Transplantation Services	80% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 80% of Allowed Amount for other covered services after Deductible	60% of Allowed Amount \$25 Copay per visit for Outpatient Physician's Visits after Deductible 60% of Allowed Amount for other covered services after Deductible
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Acupuncture Services	\$25 Copay per visit 80% of Allowed Amount after Deductible	\$25 Copay per visit 60% of Allowed Amount after Deductible
Genetic Testing	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Infertility	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Medical Foods See also Benefits for Phenylketonuria Treatment and Eosinophilic Gastrointestinal Associated Disorder	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Neurodevelopmental Therapy	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Nutritional Counseling	\$25 Copay per visit 80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Pre-exposure Inoculations Rabies series pre-exposure inoculations and rabies titer test, Veterinary Students Only. Up to \$100 each, lifetime maximum of \$300.	80% of Allowed Amount not subject to Deductible	60% of Allowed Amount not subject to Deductible
Wellness Benefit \$150 maximum per Policy Year. Includes Physician's office visits, physical examinations, and laboratory tests not otherwise covered under Preventive Care.	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible
Routine Eye Exam Covered Students age 19 and older only. Limited to one per Policy Year, up to a \$65 maximum. The maximum does not apply when services are rendered at the CHS.	100% of Allowed Amount not subject to Deductible	100% of billed charges not subject to Deductible
Vision Care Supplies Covered Students age 19 and older only. There is a combined maximum of \$200 for Lenses and Frames, including contact lenses.	100% of Allowed Amount not subject to Deductible	100% of billed charges not subject to Deductible
STD Screening Not otherwise covered under Preventive Care, the physician office visit and laboratory tests are covered including a urinalysis and the comprehensive metabolic panel.	80% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

NON-DISCRIMINATION NOTICE

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

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

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

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

If you believe that the Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can also file a grievance by writing my mail or by phone:

Washington State Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255
Phone: 1-800-562-6900 or (360) 725-7080

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

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

Online <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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

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

We also provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

Your Rights and Protections Against Surprise Medical Bills and Balance Billing In Washington State

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or on request, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, and providers must tell you which provider networks they participate in on their website or on request.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals and air ambulance providers, can **never** require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are **never** required to give your consent. Please contact your employer or health plan for more information.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at <https://www.cms.gov/nosurprises/consumers> or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at [their website](#) or by calling 1-800-562- 6900.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

Visit the [Office of the Insurance Commissioner Balance Billing Protection Act website](#) for more information about your rights under Washington state law.