UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

UNIVERSITY OF MARYLAND, BALTIMORE

2024-2025

This Certificate of Coverage is Part of Policy # 2024-1780-1

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.

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

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.

President

Administered by UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, Texas 75380-9025

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Introduction

Welcome to the UnitedHealthcare Student Resources 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.

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-800-505-4160. The Insured can also write to the Company at:

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

Section 1: Who Is Covered

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

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

All full-time undergraduate students registered for 12 or more credit hours are automatically enrolled in this insurance Plan at registration and the premium for coverage is added to their tuition billing unless proof of comparable coverage is furnished.

All full-time professional graduate students who are registered for nine or more credit hours are automatically enrolled in this insurance Plan at registration and the premium for coverage is added to their tuition billing unless proof of comparable coverage is furnished.

All graduate and professional students taking less than nine credit hours are eligible to enroll on a voluntary basis.

Any policy that limits eligibility to full-time students will not prohibit enrollment of a student over the age of 18 enrolled less than full-time as a result of a documented disability that prevents the student from maintaining a full-time course load if the student maintains at least seven credit hours per semester.

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, including a grandchild, a child placed with the Insured for legal adoption, a child of a Domestic Partner, a child for whom the Named Insured is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration, or a child for whom the Named Insured is under a court order to provide coverage. A Dependent shall also mean a Dependent of the Insured, under 26 years of age, as the term is used in 26 U.S.C. §104, 105, 106, and any regulations adopted under those sections. See the Definitions section of this Certificate for the specific requirements needed to meet Domestic Partner eligibility.

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

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

1. If a Named Insured has Dependents on the date he or she is eligible for insurance.
2. If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   a. On the date the Named Insured acquires a legal spouse 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.

Medicare Eligibility

Any person who has Medicare at the time of enrollment in this student insurance plan is not eligible for coverage under the Master Policy.

If an Insured Person obtains Medicare after the Insured Person is covered under the Master Policy, the Insured Person's coverage will not end due to obtaining Medicare.

As used here, "has Medicare" means that an individual is entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m. Eastern Time, August 1, 2024. 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. Eastern Time, July 31, 2025. The Insured Person's coverage terminates on that date or on the last day of the grace period following the period through which premium is paid, whichever is earlier, if the premium due is not paid by the last day of the grace period. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

The Insured Person must meet the eligibility requirements each time a premium payment is made. The Policy includes a Grace Period provision. To avoid a lapse in coverage, the Insured Person's premium must be received within 30 days after the coverage expiration date.

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

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

Section 3: Extension of Benefits after Termination

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

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 are payable before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the Termination Date.

If an Insured begins a course of Dental Treatment before the Termination Date and requires two or more visits on separate days to a dentist's office, Covered Medical Expenses for such course of treatment will continue to be paid but not to exceed 12 months after the Termination Date.

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

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

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 as indicated below.

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.

Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus

Preferred Provider Hospitals include UnitedHealthcare Choice Plus 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 1-800-505-4160 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 1-800-505-4160 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 will 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. Any cost share paid by the Insured Person for these services will be counted toward the applicable Preferred Provider Deductible and Preferred Provider Out-of-Pocket Maximum.

A Continuing Care Patient receiving care for Covered Medical Expenses from a Preferred Provider may choose to continue to receive transitional care from such provider if the Preferred Provider's contract is terminated due to non-renewal or expiration. The Continuing Care Patient will be eligible to request transitional 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.

If the contract between the Company and the Policyholder terminates resulting in a loss of benefits with respect to a Preferred Provider, the Company will notify each Insured who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and the Insured's right to choose transitional care.

An Insured may call the Company at 1-800-505-4160 to find out if they are considered a Continuing Care Patient, as defined in this Certificate, and 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 Company will pay according to the benefit limits in the Schedule of Benefits.

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 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.
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.

Any cost share paid by the Insured Person for these services will be counted toward the applicable Preferred Provider Deductible and Preferred Provider Out-of-Pocket Maximum.

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.

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

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

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

Benefits in these two situations will be paid at the Preferred Provider Benefits level.

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

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

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

An out-of-network on-call Physician or a Hospital-based Physician may not balance bill the Insured Person for Covered Medical Expenses when the on-call Physician or Hospital-based Physician has accepted an assignment of benefits from the Insured and has notified the Company of the assignment.

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

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

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

Continuity of Care

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

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

Examples of the conditions listed above include:

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

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

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

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

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

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

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

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

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:

Inpatient

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

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

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

Benefits will be paid for services and supplies such as:
- The cost of the operating room.
- Laboratory tests.
- Blood and blood products, both derivatives and components such as biologics, serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin and albumin.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

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

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

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

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

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

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

9. **Physician's Visits.**
Non-surgical Physician services when confined as an Inpatient.

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

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

Outpatient

11. **Surgery**.
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, Habilitative Services or Rehabilitative Services.

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

16. **Chiropractic Services.**
Services provided for the diagnosis and treatment of a Sickness or Injury.

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

See also Benefits for Habilitative Services for Children.

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

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

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

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

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

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

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy.
- Intravenous infusion therapy.
- Respiratory therapy.
- Dialysis, hemodialysis, and peritoneal dialysis.

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

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

25. **Chemotherapy.**
See Schedule of Benefits.

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

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

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

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

Other

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

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

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

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

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that are not fully implanted in the body. Benefits include the training necessary to use these prostheses.
- Nebulizers and peak flow meters.
- Durable medical equipment or supplies associated or used in conjunction with medical foods and nutritional substance.

Benefits are available for repairs and replacement, except that:

- There are no benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

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

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

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

- Injury to Sound, Natural Teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. This limitation does not apply to the Pediatric Dental Services provided under the Policy.

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

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

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

31. **Mental Illness and Substance Use Disorder Treatment.**
Benefits will be provided for the following:

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

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

- Services by pastoral or marital counselors.
- Therapy for sexual problems.
- Treatment for learning disabilities and intellectual disabilities.
- Travel time to the member's home to conduct therapy.
- Marriage counseling.

32. **Maternity**.
See Benefits for Maternity Expenses.

Benefits also include one birthing course per pregnancy.

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

34. **Preventive Care Services.**
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:

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

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

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

Benefits will be paid for:

- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Medical eye exams (dilated retinal exams).
- Preventive foot care for diabetes.
- Prescription Drugs, equipment, and supplies based on the Insured's specific medical needs, including:
  - Insulin pumps and supplies.
  - Blood glucose meters including continuous glucose monitors.
  - Insulin syringes with needles.
  - Blood glucose and urine test strips.
  - Ketone test strips and tablets.
  - Lancets and lancet devices.

Diabetes test strips will not be subject to any Deductible, Copayment and/or Coinsurance.

37. **Home Health Care.**
Services received for continued care and treatment of an Insured Person in the home when:

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

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

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

Hospice care includes, but is not limited to:

- Nursing Care provided by or under the supervision of a registered professional nurse.
- Physical or occupational therapy, or speech-language pathology services.
- Medical social services under the direction of a Physician.
- Services, including homemaker services, performed by a home health aide who has successfully completed a training program.
- Medical supplies (including drugs and biologics) and the use of medical supplies.
- Physician services.

- Short-term Inpatient care (including respite care and procedures necessary for pain control and acute and chronic symptom management) in an Inpatient facility meeting such conditions to be appropriate to provide such care. Respite care may only be provided on an intermittent, non-routine, and occasional basis and may not be provided consecutively over longer than five days.
- Counseling (including dietary counseling) with respect to care for the terminally ill Insured Person.
- Bereavement counseling provided after the Insured's death to the Immediate Family or family caregiver of the Insured to help cope with the death of the Insured Person.
- Any other item or service which is recommended by the treating Physician.

39. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered in lieu of Hospital Confinement as a full-time inpatient.

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

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

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

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

42. **Approved Clinical Trials.**
Routine Patient Care Costs incurred while taking part in an Approved Clinical Trial or a Controlled 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 or Controlled 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.

"Controlled Clinical Trial" means a treatment that is:
- Approved by an institutional review board
- Conducted for the primary purpose of determining whether or not a particular treatment is safe and efficacious; and
- Approved by any of the following:
  - An institute or center of the National Institutes of Health
  - Food and Drug Administration
  - Department of Veteran's Affairs
  - Department of Defense.

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

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

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).

- Agency for Healthcare Research and Quality (AHRQ).
- Centers for Medicare and Medicaid Services (CMS).
- A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- The Department of Veterans Affairs, the Department of Defense or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
  - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

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

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

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

44. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits in Sections 20 and 21 of this Certificate.

45. **Allergy Treatment.**
Benefits are payable for allergy testing and treatment.

Benefits include:
- Allergy testing.
- Allergy serum.
- Allergy injections, including administration of injections and allergy serum.

46. **Cardiac Rehabilitation.**
Cardiac rehabilitation benefits for Insureds who have been diagnosed with significant cardiac disease, or who have suffered a myocardial infarction, or who have undergone invasive cardiac treatment immediately preceding referral for cardiac rehabilitation. Cardiac rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling. Benefits include the following:
- Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, Physician's revision of exercise prescription, and follow-up examination for Physician to adjust medication or change regimen.
- Increased outpatient rehabilitation services for physical therapy, speech therapy and occupational therapy.

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

47. **Case Management Approved Services.**
Benefits will be paid the same as any other Sickness when treatment for any other Covered Medical Expense or service is approved by the Company's case management program.

48. **Family Planning.**
Benefits are limited to:

- Prescription contraceptive drugs or devices that are approved by the U.S. Food and Drug Administration and obtained under a prescription written by a Physician and contraceptive drugs approved by the U.S. Food and Drug Administration available by prescription but dispensed without a prescription, including over the counter contraceptives.
  - No Copay or Coinsurance will be applied to contraceptive drugs or devices unless there is a therapeutically equivalent contraceptive drug or device, according to the U.S. Food and Drug Administration, available under the Policy without a Copay or Coinsurance.
  - Benefits are available for a single dispensing of a 12-month supply of a contraceptive. If a 12-month supply extends beyond the Policy termination date, benefits will be provided for the number of months up to the Policy termination date.
- The insertion or removal of a contraceptive device and any medical examination associated with the use of a contraceptive drug or device.
- Voluntary sterilization. No Deductible, Copay or Coinsurance will be applied to male sterilization.

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

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

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

Benefits for in vitro fertilization are payable if any of the following has occurred:

- For a married patient, whose spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's spouse's sperm, except when the patient's spouse is unable to produce and deliver functional sperm. The exception does not apply when the inability to produce and deliver functional sperm is a result from a vasectomy or any other method of voluntary sterilization.
- For a married patient, the patient and the patient's spouse who are of the opposite sex have a history of involuntary infertility of at least a 1 year duration, demonstrated through intercourse and failing to result in pregnancy.
- For a married patient, the patient and patient's spouse who are of the same sex, have a history of involuntary infertility demonstrated through 3 attempts of artificial insemination over the course of 1 year and failing to result in pregnancy.
- For an unmarried patient, the patient has had 3 attempts of artificial insemination over the course of 1 year failing to result in pregnancy.
- The infertility of the patient is associated with any of the following medical conditions:
  - Endometriosis.
  - Exposure in utero to diethylstilbestrol, commonly known as DES.
  - Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy).
  - Abnormal male factors, including oligospermia, contributing to the infertility.
- The Insured has been unable to attain a successful pregnancy demonstrated through a less costly infertility treatment for which coverage is available under the Policy.

In vitro fertilization procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists or the American Fertility Society for reproductive medicine guidelines and minimal standards.

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

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

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

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

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

Unless specified in the Schedule of Benefits, Infertility Services do not include:
- Ovum transplants.
- Gamete intrafallopian tube transfer.
- Zygote intrafallopian transfer.
- Cryogenic or other preservation techniques.
- Costs incurred for obtaining donor sperm.

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

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

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

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

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

55. **Wellness Benefits.**
Benefits will be provided to the Named Insured for exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and/or programs that promote cardiovascular wellness.

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

In order to be eligible for benefits, the Insured must:
- Be an active member of the exercise facility; and
- Complete 50 visits in a six month period.

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

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

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

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

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

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

56. **Wigs.**
Wigs and other scalp hair prosthesis when prescribed by the Insured's attending Physician for the treatment of hair loss.

Section 7: Mandated Benefits

Benefits for Maternity Expenses

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

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

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

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

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

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

"Home visit" shall:

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

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

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

Benefits for Prostate Cancer Screening

Benefit will be paid for that portion of charges which is not in excess of the Allowed Amount for expenses incurred in conducting a medically recognized prostate cancer screening diagnostic examination. Benefits include a digital rectal exam and a prostate-specific antigen (PSA) tests subject to any of the following requirements:

1. For men between the ages of 40 and 75.
2. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment.
3. When used for staging in determining the need for a bone scan in patients with prostate cancer.
4. When used for men who are at high risk for prostate cancer.

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

Benefits for Reconstructive Breast Surgery Following a Mastectomy

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

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

“Reconstructive Breast Surgery” means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.
Benefits shall not be subject to benefit limitations for specific types of services. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the Policy.

Benefits for Mammography

Benefits will be paid for breast cancer screening under the Preventive Care Services benefit or under this benefit, whichever is greater.

Breast cancer screenings covered by the Preventive Care Services benefit will be paid as specified in the Preventive Care Services benefit in the Schedule of Benefits.

Breast cancer screenings payable under this benefit will be paid for that portion of charges which is not in excess of the Allowed Amount for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society.

Benefits shall include coverage for Digital Tomosynthesis that, under accepted standards in the practice of medicine, the treating Physician determines is medically appropriate and necessary for an Insured Person.

Breast cancer screenings used to identify breast cancer in asymptomatic women, including Digital Tomosynthesis, must be provided in facilities accredited by the American College of Radiology or certified or licensed under a program established by the state of Maryland.

“Digital Tomosynthesis” means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

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

Benefits for Morbid Obesity

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

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

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

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

Benefits for Habilitative Services for Children

Benefits will be paid for that portion of charges which is not in excess of the Allowed Amount for Habilitative Services for an Insured Person under the age of 19 years, which includes the treatment of autism and autism spectrum disorder. Benefits will not be paid for Habilitative Services delivered through early intervention or school services.

"Habilitative services" within this benefit means services and devices designed to help a person keep, learn, or improve skills and functioning for daily living (such as therapy for a child who is not walking or talking at the expected age). Benefits include occupational therapy, physical therapy, speech therapy, and other services for the treatment of a child with a disability.

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

This benefit is subject to all Deductible, Copayments, Coinsurance, or any other provisions of the Policy.

Benefits for PANDAS and PANS

Benefits will be paid for the diagnosis, evaluation and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including intravenous immunoglobulin therapy, to the same extent as any other Sickness.

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

Benefits for Diagnostic and Supplemental Breast Examinations

Benefits will be paid for the screening and diagnosis of breast cancer including diagnostic or supplemental breast examinations as indicated.

"Diagnostic breast examination" means a medically appropriate and necessary examination of the breast that is used to evaluate an abnormality that is seen or suspected from a prior screening examination for breast cancer or detected by another means of prior exam. Diagnostic breast exam includes diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound.

"Supplemental breast examination" means a medically appropriate and necessary examination that is used to screen for breast cancer when there is no abnormality seen or suspected from a prior examination and there is a personal or family medical history or additional factors that may increase an Insured's risk of breast cancer. Supplemental breast examination includes an examination using breast magnetic resonance imaging or breast ultrasound.

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

Benefits for Lung Cancer Diagnostic Imaging

Benefits will be paid for follow-up diagnostic imaging to assist in the diagnosis of lung cancer as recommended by the U.S. Preventive Services Task Force.

Coverage includes the following services:

1. Diagnostic ultrasounds
2. Magnetic resonance imaging
3. CT scans
4. Image-guided biopsies.

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

Benefits for Biomarker Testing

Benefits will be provided for Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of disease or condition that is supported by medical and scientific evidence, including testing:

1. Cleared or approved by the U.S. Food and Drug Administration.
2. Required or recommended for a drug approved by the U.S. Food and Drug Administration to ensure an Insured is a good candidate for the drug treatment.
3. Required or recommended through a warning or precaution for a drug approved by the U.S. Food and Drug Administration to identify whether an Insured will have an adverse reaction to the drug treatment or dosage.
4. Covered under a Centers for Medicare and Medicaid Services National Coverage Determination or Medicare Administrative Contractor Local Coverage Determination.
5. Supported by nationally recognized clinical practice guidelines that are both:
   - Developed by independent organizations or medical professional societies using a transparent methodology and reporting structure and that have a conflict of interest policy.
   - Established standards of care informed by a systematic review of evidence and assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarker includes gene mutations, characteristics of genes, or protein expression.

"Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a Biomarker, the results of which:

1. Provide information that may be used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.
2. Include both information that is actionable and some information that cannot be immediately used in the formulation of a clinical decision.

Biomarker testing includes single-analyte tests, multi-plex panel tests, protein, expression, and whole exome, whole genome, and whole transcriptome sequencing.

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

Section 8: Coordination of Benefits Provision

Benefits will be coordinated with any other eligible medical, surgical, or hospital Plan or coverage so that combined payments under all programs will not exceed 100% of Allowable Expenses incurred for covered services and supplies.

Definitions

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

- For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.
- If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

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

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

   Plan includes all of the following:
   - Group insurance contracts and subscriber contracts.
   - Uninsured arrangements of group or group-type coverage.
   - Group coverage through closed panel Plans.
   - Group-type contracts, including blanket contracts.
   - The medical care components of long-term care contracts, such as skilled nursing care.
   - Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of Plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

   Plan does not include any of the following:

   - Hospital indemnity coverage benefits or other fixed indemnity coverage.
   - Accident only coverage.
   - Limited benefit health coverage as defined by state law.
   - Specified disease or specified accident coverage.
   - School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
   - 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.
   - Medicare supplement policies.
   - State Plans under Medicaid.
   - A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.
   - An Individual Health Insurance Contract.

3. **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.

4. **Secondary Plan:** A Plan that is not the Primary Plan.

5. **We, Us or Our:** The Company named in the Policy.

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

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

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan

shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

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

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

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

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

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

2. **Dependent Child/Parents Married or Living Together.** When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:
   - the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
   - However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

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

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

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

   If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:
   - First, the Plan of the parent with custody of the child.
   - Then the Plan of the spouse of the parent with the custody of the child.
   - The Plan of the parent not having custody of the child.
   - Finally, the Plan of the spouse of the parent not having custody of the child.

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

5. **Dependent Child/Parental and Spousal Coverage.** If a Dependent child has coverage under either or both parents' plans and also has his or her own coverage as a Dependent under a spouse's plan, the order of benefit determination shall be the same as provided under paragraph (8) for Longer/Shorter Length of Coverage.

   In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by the following:
   - The benefits of the Plan of the parent/spouse whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent/spouse whose birthday falls later in that year.
   - However, if both the parents and spouse have the same birthday, the benefits of the Plan which covered the parent or spouse longer are determined before those of the Plan which covered the other parent/spouse for a shorter period of time.

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

7. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
   - First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
   - Second, the benefits under the COBRA or continuation coverage.
   - If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

   To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended. The start of the new plan does not include:
   - A change in the amount or scope of a plan's benefits.
   - A change in the entity that pays, provides, or administers the plan's benefits.
   - A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

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

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

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

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

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

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

Section 9: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

For Loss Of	
Life	$10,000.00
Two or More Members	$10,000.00
One Member	$5,000.00
Thumb or Index Finger	$2,500.00

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

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

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

Section 10: Definitions

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

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

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

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. Under specified Maryland law, for an on-call Physician or hospital based Physician who has obtained an assignment of benefits from the Insured, this is the amount required by §14-205.2 of the Insurance Article.
   - 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. Under specified Maryland law, for an on-call Physician or hospital based Physician who has obtained an assignment of benefits from the Insured, this is the amount required by §14-205.2 of the Insurance Article.
   - 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, including non-physician practitioners.
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 or from birth, including a hereditary defect. A congenital condition includes but is not limited to:

1. Autism or autism spectrum disorder;
2. Cerebral palsy;
3. Intellectual disability;
4. Down syndrome;
5. Spina bifida;
6. Hydroencephalocele;
7. Congenital or genetic development disabilities.

CONTINUING CARE PATIENT means an Insured Person who, with respect to a provider or facility, meets any of the following conditions:

1. Is undergoing a course of treatment for a serious and complex condition from the provider or facility.
2. Is undergoing a course of institutional or Inpatient care from the provider or facility.
3. Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery.
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility.
5. Is or has been determined to be terminally ill and is receiving treatment for such illness from such provider or facility.

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

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

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. Specified as a covered medical expense in this Certificate under the Medical Expense Benefits or in the Schedule of Benefits.
3. Not in excess of the Allowed Amount or the Recognized Amount when applicable.
4. Not in excess of the maximum benefit payable per service as specified in the Schedule of Benefits.
5. Not excluded in this Certificate under the Exclusions and Limitations.
6. 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 the amount of Covered Medical Expenses that must be incurred by the Insured Person before becoming eligible for Policy benefits. The deductible is subtracted from the amount or amounts otherwise payable as Covered Medical Expenses. The deductible will apply as specified in the Schedule of Benefits.

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

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

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

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

1. Incapable of self-support because of mental or physical incapacity.
2. Chiefly dependent upon the Insured Person for support and maintenance.

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

If a claim is denied under the Policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be incapacitated as defined by subsections (1) and (2). The regular dependent premium will be charged to continue coverage for mentally or physically incapacitated dependent children.

DOMESTIC PARTNER means a person of the same or opposite sex who is neither married nor related by blood or marriage within four degrees of consanguinity to the Named Insured but who:

1. Is the Named Insured’s sole spousal equivalent.
2. Lives together with the Named Insured in the same residence.

3. Contributes with the Named Insured for each other's welfare with the intention of remaining in the relationship indefinitely.

Proof of a domestic partner relationship can be demonstrated by one of the following common primary financial interdependence documents:

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

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

EMERGENCY SERVICES means, with respect to a Medical Emergency, both:

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Medical Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.
2. Any other examination and treatment within the capabilities of the staff and facilities available at the Hospital or Independent Freestanding Medical Department to stabilize the patient (regardless of the department of the Hospital in which such further exam and 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)*).

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. The notice must have included all of the following:
   a. A list of participating providers at the facility who are able to furnish such items and services involved.
   b. Notification that the Insured Person, at their option, can be referred to a participating provider.
   c. A good faith estimated amount that the Insured Person may be charged for items or services furnished by the Out-of-Network Provider or facility with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the nonparticipating emergency facility or nonparticipating providers in conjunction with such items or services).
3. The Insured Person (or their authorized representative who is authorized under state law to provide consent on behalf of the Insured Person) 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.
5. The covered services are not rendered by an on-call physician or hospital-based Physician who has obtained an assignment of benefits from the Insured Person.

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.

EXPERIMENTAL SERVICE means medical, dental, surgical, diagnostic, psychiatric, substance misuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that

is current when the care is rendered. Experimental services do not include Approved Clinical Trials as specifically provided for in the Policy.

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

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

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

HOSPITAL means a licensed or properly accredited general hospital which is all of the following:

1. Open at all times.
2. Operated primarily and continuously for the treatment of sick and injured persons as inpatients.
3. Under the supervision of a staff of one or more legally qualified Physicians available at all times.
4. Continuously provides on the premises 24 hour nursing service by Registered Nurses.
5. Provides organized facilities for diagnosis on the premises.
6. Not primarily a clinic, nursing, rest or convalescent home.

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

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

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 an accident which is unrelated to any pathological, functional, or structural disorder.
2. A source of loss.
3. Treated by a Physician within 30 days after the date of accident.
4. Sustained while the Insured Person is covered under the Policy.

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

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

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the 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.

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

MEDICAL EMERGENCY means a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including the sudden and unexpected onset of a condition involving severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention 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.

MEDICARE means Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the 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 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed Congenital Conditions, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

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

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

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

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

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. Under specified Maryland law, for an on-call Physician or hospital based Physician who has obtained an assignment of benefits from the Insured, this is the amount required by §14-205.2 of the Insurance Article.
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 state and federal 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)*.

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

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

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

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

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

TELEHEALTH/TELEMEDICINE means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the Insured. Telehealth services will be provided regardless of the location of the Insured Person at the time of services. "Telehealth" includes audio-only telephone conversation between a health care provider and an Insured resulting in the delivery of billable Covered Medical Expenses. "Telehealth" does not include audio-only telephone conversation that does not result in the delivery of a billable Covered Medical Expense, electronic mail message, or facsimile transmission between a health care provider and the Insured Person.

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

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

Section 11: Exclusions and Limitations

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

1. Sexual dysfunction not related to organic disease.
2. Cosmetic procedures, surgery, or related services to improve appearance.
   This exclusion does not apply to reconstructive procedures to restore bodily function or correct deformity resulting from disease, trauma or congenital or developmental anomalies for which benefits are otherwise payable under the Policy, as determined by the treating Physician.
3. Personal care services and domiciliary care services.
4. Dental treatment which includes Hospital or professional care in connection with:
   - The operation or treatment for the fitting or wearing of dentures.
   - Orthodontic care or malocclusion.
   - Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of Injury to natural teeth due to an accident if the treatment is received within 6 months of the accident.
   - Dental implants.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services and benefits specified under Dental Treatment in the Policy.
5. Experimental Services.
6. Foot care for the following:
   - Supportive devices for the foot, including arch supports, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports or exams for their prescription or fitting.
   - Routine foot care including the care, cutting and removal of corns, calluses, and toenails.

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease or treatment of a covered Injury or Sickness, as determined necessary by the treating Physician.
7. Lifestyle improvements, including nutritional counseling, or physical fitness programs, except as specifically provided in the Policy.
8. The purchase, examination, or fitting of hearing aids or supplies, and tinnitus maskers. This exclusion does not apply to:
   - Treatment for hearing defects or hearing loss as a result of a Congenital Condition, infection, or Injury. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
   - Hearing aids as specifically provided in the Policy.
9. Immunizations related to foreign travel.
10. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
11. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except when traveling for academic study abroad programs, business or pleasure.

12. Services resulting from accidental bodily Injury arising out of a motor vehicle accident to the extent that services are payable under a medical expense payment provision of an automobile insurance policy.
13. Reproductive services as follows, except as specifically provided in Infertility Services:
    - Services to reverse a voluntary sterilization procedure.
    - Services for sterilization or reverse sterilization for a Dependent minor, except for FDA approved sterilization procedures for women with reproductive capacity.
14. The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of an Injury or Sickness.
    This exclusion does not apply to benefits specifically provided in Pediatric Vision Services.
15. Services performed or prescribed under the direction of a person who is not a Physician or performed beyond the scope of practice of the Physician.
16. Services for which the Insured Person is not legally, or as a customary practice, required to pay in the absence of an Insurance policy.
17. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except surgery to treat joint abnormalities due to Injury and Sickness and where clear demonstrable radiographic evidence of joint abnormality exists.
18. Services to the extent they are covered by any government unit, except for veterans in Veteran's Administration or armed forces facilities for services received for which the Insured is liable.
19. Medical or surgical treatment or regimen for reducing or controlling weight. This exclusion does not apply to:
    - Benefits specifically provided in Benefits for Morbid Obesity.
    - Benefits specifically provided in Nutritional Services.

Section 12: 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 or Infirmary, or when not in school, to their Physician or Hospital.
2. A Company claim form is not required for filing a claim. 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.
3. Written proof of loss submitted by a provider must be furnished to the Company within 180 days from the date a covered service is rendered. Submit claims for payment within one year after the date of service. Failure to furnish bills within one year after the date of service will not invalidate or reduce any claim if it was not reasonably possible to furnish the proof of loss within the time required and that proof of loss was submitted as soon as reasonably possible. When it is not reasonably possible to submit the bills within the time required; the time limit to submit the claim will be extended to two years after the date of service. In the event the Insured Person is legally incapacitated and unable to submit a claim, the time limit to submit the claim will be suspended. When legal capacity is regained, the suspension period ends and the claim should be submitted as soon as reasonably possible. If the Insured doesn't provide this information within the time allowed, benefits for that service may be denied at our discretion.

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

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

Section 13: General Provisions

GRACE PERIOD: A grace period of 30 days will be provided for the payment of each premium payment due after the first premium. The Insured Person's premium must be received during the grace period to avoid a lapse in coverage, and the Insured Person must meet the eligibility requirements each time a premium payment is made.

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

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss submitted by a provider must be furnished to the Company within 180 days from the date a covered service is rendered. Written proof of loss must be furnished to the Company at its said office within one year after the date of service. Failure to furnish such proof within one year after the date of service will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within the time required and that proof of loss was submitted as soon as was reasonably possible. When it is not reasonably possible for the Insured Person to submit the claim within the time required; the time limit to submit the claim will be extended to two years after the date of service. In the event the Insured Person is legally incapacitated and unable to submit a claim, the time limit to submit the claim will be suspended. When legal capacity is regained, the suspension period ends and the claim should be submitted as soon as reasonably possible. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than two years from the date of service.

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

If the Company fails to pay a clean claim for such loss within the 30 day time limit stated above, the Company shall pay interest on the amount of the claim at the monthly rate of: 1.5% from 31st day through the 60th day, 2% from the 61st day through the 120th day and 2.5% after the 120th day.

A clean claim is a claim for reimbursement submitted to the Company that contains essential data elements and any attachments defined under Maryland Insurance Regulations COMAR 31.10.11.02.

PAYMENT OF CLAIMS: All indemnities provided by the Policy will be payable 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. Any accrued indemnities unpaid at the Named Insured's death may, at the option of the Company, be paid to the estate of the Named Insured or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release. The Company may pay up to an amount not exceeding $5,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

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.

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

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

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received.

STANDARD OF TIME: All times referenced shall be at the place the Policy is delivered.

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 three 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 Company's recovery amount will be reduced by the Company's pro-rata share of the Insured's court cost and attorney fees. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

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

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

Section 14: Notice of Complaint Process for Coverage Decisions

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

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

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

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

Notification of Coverage Decision
Written notice will be provided within 30 calendar days when a Coverage Decision is made. The notification will include:
1. The factual basis for the Company's Coverage Decision, including references to specific criteria or standards and interpretive guidelines on which the determination was based;
2. The Insured Person or Authorized Representatives, including health care providers, right to file an appeal with the Company;
3. Details of the Company's Internal appeal process and procedures, which shall include:
   a. A statement of the Insured Person or an Authorized Representative's, including health care providers, right to file a complaint with the Maryland Commissioner of Insurance without first filing an appeal with the Company, if there is an Urgent Medical Condition to do so as determined by the Commissioner;
   b. The address, telephone and fax number of the Maryland Commissioner of Insurance;
   c. The address, telephone and fax number, and e-mail address of the Health Advocacy Unit with a statement informing the Insured Person, or the Insured's Authorized Representative, including a health care provider, assistance is available through the Health Advocacy Unit for both mediating and filing an appeal under the Company's internal appeal process.

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

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.

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

If the Company does not have sufficient information to complete the internal appeal process, the Company, within five working days of receipt of request for internal appeal shall:

1. Notify the Insured Person or the Authorized Representative, the Company cannot proceed with the internal review unless additional information is provided; and
2. Assist the Insured Person or Authorized Representative with gathering the necessary information.

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

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

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

Within 30 calendar days after a Final Appeal Decision has been made, the Company shall issue a written notice of the Final Appeal Decision to the Insured Person or the Authorized Representative.

The written notice of Final Appeal Decision 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 appeal, 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, including the health care provider, upon request;
4. For an Internal Review decision that upholds the Company's original Coverage Decision:
    a. The factual basis for the Final Appeal Decision, 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, or the Insured's Authorized Representative, including the health care provider, 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. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Appeal Decision; 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 Appeal Decision with the following information included:
    a. The factual basis for the Company's Coverage Decision, including references to specific criteria or standards and interpretive guidelines on which the determination was based;
    b. The Insured Person's right to file a complaint or request for External Independent Review with the Commissioner within four months after receiving the Company's Final Appeal Decision;
    c. The Commissioner's address, telephone number, and facsimile number;
    d. A statement the Health Advocacy Unit is available to assist the Insured Person with filing a request for External Independent Review with the Commissioner; and
    e. The address, telephone and facsimile number, and e-mail address of the Health Advocacy Unit.

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.

Expedited Internal Review

For Urgent Medical Conditions, an Insured Person or their Authorized Representative may submit a request, either orally or in writing, for an Expedited Internal Review (EIR).

An Urgent Medical Condition means a condition that satisfies either of the following:

1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Company, applying judgement of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
    a. Placing the Insured's life or health in serious jeopardy;
    b. The inability of the Insured to regain maximum function;
    c. Serious impairment to bodily function;

d. Serious dysfunction of any bodily organ or part; or
e. The Insured remaining seriously mentally ill with symptoms that cause the Insured to be a danger to self or others;

2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Insured's medical condition, would subject the Insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

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, P.O. 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 a Coverage Decision:

1. Involving Urgent Medical Conditions; and
2. Related to a concurrent review of an Urgent Medical Condition 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 Company shall, within one day after orally communicating the Company's decision, send written notice of the Coverage Decision to the Insured Person or the Authorized Representative. The Insured Person or the Authorized Representative shall be notified of the EIR decision no more than twenty-four (24) hours after the Company's receipt of the EIR request.

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

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file an External Independent Review request with the Commissioner 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

The notice of Final Appeal Decision may be provided orally, in writing, or electronically.

The written notice of Final Appeal Decision for the Expedited Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review.
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount.
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request.
4. For an Internal Review decision that upholds the Company's original Coverage Decision:
   a. The factual basis for the Final Appeal Decision, 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, or the Insured's Authorized Representative, 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; and
   e. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Appeal Decision; 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 Appeal Decision with the following information included:
   a. The factual basis for the Company's Coverage Decision, including references to specific criteria or standards and interpretive guidelines on which the determination was based;

b. The Insured's right to file a complaint or request for External Independent Review with the Commissioner within four months after receiving the Company's Final Appeal Decision;
c. The Commissioner's address, telephone number, and facsimile number;
d. A statement the Health Advocacy Unit is available to assist the Insured Person with filing a request for External Independent Review with the Commissioner; and
e. The address, telephone and facsimile number, and e-mail address of the Health Advocacy Unit.

RIGHT TO EXTERNAL INDEPENDENT REVIEW
After exhausting the Internal Appeal process, and after receiving notice of a Final Appeal Decision, an Insured Person or Authorized Representative has four months to request an External Independent Review. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review. The Commissioner shall make and issue in writing a final decision on all External Independent Review requests filed within the Commissioner's jurisdiction.

An Insured Person or Authorized Representative may submit a request for an External Independent Review when the service or treatment in question is a Covered Medical Expense under the Policy

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 Appeal Decision 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 60 working days after the date on which the appeal is filed and the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Insured Person or the Authorized Representative filed a request for an Expedited Internal Appeal and has not received a written decision from the Company within twenty-four (24) hours and the Insured Person, Authorized Representative has not requested or agreed to a delay;
4. The Company fails to strictly adhere to the Internal Appeal process detailed herein;
5. The Company agrees to waive the exhaustion requirement; or
6. The Insured Person or Authorized Representative provides sufficient and supporting information to the Commissioner demonstrating an Urgent Medical Condition for external review.

Where to Send External Review Requests
All types of External Review requests shall be submitted to the Maryland Insurance Administration at the following address:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2000 or 1-800-492-6116 TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260 (Life and Health/Appeals and Grievance)

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

Appeal means a protest filed by an Insured, an Insured's Authorized Representative, or a health care provider with the Company under its Internal Appeal Process regarding a Coverage Decision concerning the Insured Person.

Authorized Representative means:
1. A person to whom an Insured Person has given express written consent to represent the Insured Person, including a health care provider;
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 Medical Condition, a health care professional with knowledge of the Insured Person's medical condition.

Complaint means a protest filed with the Commissioner involving a Coverage Decision.

Coverage Decision means:
1. A determination by the Company that the Insured is not eligible for coverage under the Policy as an Insured Person;

2. An initial determination by the Company or the Company's representative that results in noncoverage of a health care service;
3. Any determination by the Company that results in the rescission of an Insured's coverage under the Policy.

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 Appeal Decision means a determination arising from an appeal filed with the Company under its appeal process involving a Covered Medical Expense issued at the completion of the Company's internal appeal process or Coverage Decision for which the internal appeals process has been deemed exhausted in accordance with this notice.

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

Urgent Medical Condition means a condition that satisfies either of the following:
1. A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of the Company, applying judgement of a prudent layperson who possesses an average knowledge of health and medicine, to result in:
   a. Placing the Insured's life or health in serious jeopardy;
   b. The inability of the Insured to regain maximum function;
   c. Serious impairment to bodily function;
   d. Serious dysfunction of any bodily organ or part; or
   e. The Insured remaining seriously mentally ill with symptoms that cause the Insured to be a danger to self or others;
2. A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the Insured's medical condition, would subject the Insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

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

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

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

Section 15: Maryland Mental Health Parity and Addiction Equity Act Subscriber Notice

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

Section 16: Online Access to Account Information

UnitedHealthcare Student Resources Insureds have online access to claims status, EOBs, ID cards, network providers, correspondence, and coverage information by logging in to My Account at www.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 Student Resources' environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes 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 17: ID Cards

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

Section 18: UHCSR Mobile App

The UHCSR Mobile App is available for download from Google Play or 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 19: 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
1-800-505-4160
Website: www.uhcsr.com

Section 20: Pediatric Dental Services Benefit

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 Out-of-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 an out-of-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 the Company at the number stated on their identification (ID) card to determine which providers participate in the Network.

Out-of-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services from out-of-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Out-of-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 an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay an out-of-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 out-of-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 provided by or under the direction of a Network Dental Provider.

Benefits are available only for Covered Dental Services listed under this provision. 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.

Section 2: Benefits for Pediatric Dental Services

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

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

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

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 a Covered Dental Service. If the Insured Person agrees to receive a service or supply that is not a Covered Dental Service, the Network provider may charge the Insured Person. However, these charges will not be considered Covered Dental Services and benefits will not be payable.

Out-of-Network Benefits:

Benefits for Allowed Dental Amounts from out-of-Network providers are determined as a percentage of the Usual and Customary Fees. The Insured Person must pay the amount by which the out-of-Network provider's billed charge exceeds the Allowed Dental Amounts. The Usual and Customary Fee for Covered Dental Services provided by an out-of-Network provider will not be less than the Allowed Dental Amount for a similarly licensed Network provider for the same service in the same geographic region.

Dental Services Deductible

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

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

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

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

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

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

Benefit Description

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**	**Out-of-Network Benefits**
Diagnostic Services - (Subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) Periodic Oral Evaluation provided in accordance with the periodicity schedule developed by the American Academy of Pediatric Dentistry. D0120 - Periodic oral evaluation per provider or location D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0145 - Oral Evaluation for patients under three years of age D0150 - Comprehensive oral evaluation- new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient D0160 - Detailed and extensive oral evaluation - problem focused, by report	100%	100%
Intraoral Radiographs (X-ray) Limited to one series of films per 36 months per provider or location.	100%	100%

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**	**Out-of-Network Benefits**
D0210 - Intraoral - comprehensive series of radiographic images D0709 - Intraoral - comprehensive series of radiographic images - image capture only D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only		
The following services are limited to two per 12 months. D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal film D0250 - Extra-oral - 2D projection D0374 - Intraoral tomosynthesis - periapical radiographic image D0389 - Intraoral tomosynthesis - periapical radiographic image - image capture only D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only	100%	100%
The following services is not subject to a frequency limit. D0270 - Bitewing - single radiographic image	100%	100%
Any combination of the following services is limited to two series of films per 12 months. D0272 - Bitewings - two radiographic images D0273 - Bitewings - three films radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only	100%	100%

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**	**Out-of-Network Benefits**
D0708 - Intraoral - bitewing radiographic image - image capture only		
Limited to one set per 36 months. D0310 - Sialography D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only	100%	100%
The following service is limited to two images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	100%	100%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0460 - Pulp Vitality Test D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	100%	100%
Preventive Services - (Subject to payment of the Dental Services Deductible.) Pediatric dental services falling under the USPSTF and HRSA guidelines will not be subject to cost sharing.		
Dental Prophylaxis (Cleanings) The following services are limited to one every 120 days. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	100%	100%
Fluoride Treatments Topical fluoride varnish is limited to 8 units per 12 months for ages 0 to 2 years, 4 units per 12 months for ages over 3 years, and 4 units per 12 months per provider or location. Topical application of fluoride is limited to one treatment per 120 days. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride- excluding varnish	100%	100%

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**	**Out-of-Network Benefits**
Sealants (Protective Coating) The following services are limited to once per permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations per tooth in moderate to high caries risk patient - permanent tooth	100%	100%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. 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 D1555 - Removal of fixed space maintainer 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	100%	100%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent	50%	50%

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**	**Out-of-Network Benefits**
D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent		
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. 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 incisal angle (anterior) D2390 - Resin-based composite crown, anterior D2391 - Resin-based composite - one surface, posterior D2392 - Resin-based composite - two surfaces, posterior D2393 - Resin - based composite - three surfaces, posterior D2394 - resin-based composite - 4 or more surfaces, posterior	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of one time every 36 months. Pre-fabricated stainless steel permanent tooth crown is limited to one time per tooth per 36 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2721 - Crown - resin with predominantly base metal D2740 - Crown - porcelain/ceramic 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	50%	50%

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**	**Out-of-Network Benefits**
D2781 - Crown - 3/4 cast predominately base metal D2782 - Crown - 3/4 cast noble 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 D2932 - Prefabricated resin crown D2933 - Prefabricated stainless steel crown with resin window D2934 - Prefabricated esthetic coated stainless steel crown - primary tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following service is limited to one time per patient per tooth every 36 months. D2928 - Prefabricated porcelain/ceramic crown - permanent tooth The following services are limited to one time per patient per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth D2950 - Core buildup, including any pins when required D2952 - Post and core in addition to crown, indirectly fabricated D2955 - Post removal D2960 - Labial veneer (resin laminate) - chairside D2961 - Labial veneer (resin laminate) - laboratory	50%	50%

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**	**Out-of-Network Benefits**
D2962 - Labial veneer (porcelain laminate)		
The following service are not subject to a frequency limit. D2951 - Pin retention - per tooth, in addition to restoration D2954 - Prefabricated post and core in addition to crown D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D3110 - Pulp Cap - direct D3120 - Pulp Cap - Indirect	50%	50%
The following services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration) D3221 - Pulpal debridement, primary and permanent teeth D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3310 - Endodontic therapy, anterior tooth (excluding final restoration) D3320 - Endodontic therapy, premolar tooth (excluding final restoration) D3330 - Endodontic therapy, molar tooth (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	50%	50%
The following services are not subject to a frequency limit.	50%	50%

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**	**Out-of-Network Benefits**
D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit		
The following services are not subject to a frequency limit. D3355 - Pulpal regeneration - initial visit D3356 - Pulpal regeneration - interim medication replacement D3357 - Pulpal regeneration - completion of treatment	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy - (each additional root) D3450 - Root amputation - per root D3427 - Periradicular surgery without apicoectomy D3430 - Retrograde filling - per 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	50%	50%
The following service is not subject to a frequency limit. D3470 - Intentional re-implantation	50%	50%
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%

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**	**Out-of-Network Benefits**
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 24 months, per quadrant. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following services are limited to one every 24 months, per quadrant. D4230 - Anatomical crown exposure - four or more teeth D4231 - Anatomical crown exposure - one to three teeth per quadrant D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following services are limited to one every 24 months, per tooth. D4249 - Clinical crown lengthening - hard tissue	50%	50%
The following services are limited to one every 24 months, per quadrant. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft retained natural tooth - first site in quadrant D4286 - Removal of non-resorbable barrier	50%	50%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure	50%	50%

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**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns	50%	50%
The following services are limited to one time per quadrant every 24 months. D4320 - Provisional splinting - Intracoronal D4321 - Provisional splinting - extracoronal 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	50%	50%
The following service is limited to a frequency to one per 24 months. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%	50%
The following services are limited to four times every 12 months. D4910 - Periodontal maintenance D4920 - Unscheduled dressing change (by someone other than treating dentist or their staff)	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary	50%	50%

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**	**Out-of-Network Benefits**
D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular 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 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) D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5225 - Maxillary partial denture-flexible base D5226 - Mandibular partial denture - flexible base 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		

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**	**Out-of-Network Benefits**
(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 D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture (each tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary 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	50%	50%
The following services are limited to rebasing performed more than six months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis	50%	50%

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**	**Out-of-Network Benefits**
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)		
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular) D5863 - Overdenture - complete maxillary D5864 - Overdenture - partial maxillary D5865 - Overdenture - complete mandibular D5866 - Overdenture - partial mandibular	50%	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
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 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	50%	50%
The following services are not subject to a frequency limit.	50%	50%

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**	**Out-of-Network Benefits**
D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis		
The following services are limited to one 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 D6792 - Retainer crown - full cast noble metal	50%	50%
The following services are not subject to a frequency limit. D6930 - Re-cement or re-bond FPD D6980 - FPD repair necessitated by restorative material failure	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D7111 - Extraction, coronal remnants *D7140 - Extraction, erupted tooth or exposed root* D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated D7220 - Removal of impacted tooth - soft tissue	50%	50%

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**	**Out-of-Network Benefits**
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, impacted teeth only D7260 - Orontral fistula closure		
The following services are not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth D7272 - Tooth reimplantation (includes from one site to another)	50%	50%
The following services are not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth D7285 - Incisional biopsy of oral tissue - hard D7286 - Incisional biopsy of oral tissue - soft D7290 - Surgical repositioning of teeth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant D7340 and D7350 - Vestibulopasty	50%	50%
The following services are not subject to a frequency limit. D7410 - Excision of benign lesion up to 1.25 cm D7440 - Excision of malignant tumor - lesion up to 1.25 cm	50%	50%

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**	**Out-of-Network Benefits**
D7450 - Removal of benign odontogenic cyst or tumor - up to 1.25cm D7451 - Removal of benign odontogenic cyst or tumor - greater than 1.25cm D7460 - Removal of benign nonodontogenic cyst or tumor - up to 1.25cm D7461 - Removal of nonodontogenic cyst or tumor - lesion greater than 1.25cm D7471 - Removal of lateral exostosis (maxilla or mandible) D7472 - Removal of torus palatinus D7473 - Removal of torus mandibularis		
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst D7510 - Incision and drainage of abscess, intraoral soft tissue D7520 - Incision and drainage of abscess - extraoral soft tissue D7550 - Partial ostectomy D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7960 – Frenulectomy D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7970 - Excision of hyperplastic tissue per arch D7971 - Excision of pericoronal gingiva	50%	50%
The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
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.	50%	50 %

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**	**Out-of-Network Benefits**
D9110 - Palliative treatment of dental pain - per visit		
D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9230 - Inhalation of nitrous oxide/analgesia, anxiolysis D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9243 - Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment D9248 - Non-intravenous conscious sedation D9610 - Therapeutic parenteral drug single administration	50%	50%
D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment) D9410 - House/extended facility call D9910 - application of desensitizing medicament	50%	50%
The following is limited to one guard every 12 months. D9941 - Fabrication of athletic mouth guard	50%	50%
D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch D9951 - Occlusal adjustment - limited D9952 - Occlusal adjustment - complete	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement: transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement	50%	50%

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**	**Out-of-Network Benefits**
D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) 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 FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD- porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD- high noble alloys 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		

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**	**Out-of-Network Benefits**
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 D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6095 - Repair implant abutment, by report 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 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of 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		

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**	**Out-of-Network Benefits**
D6190 - Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		
The following services are not subject to a frequency limit. D6105 - Removal of implant body not requiring bone removal or flap elevation D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	50%	50%
The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant D6107 - Guided tissue regeneration - non-resorbable barrier, per implant	50%	50%
Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is related to any of the identifiable syndromes listed above.		
The following services are not subject to a frequency limitation. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8090 - Comprehensive orthodontic treatment of the adult dentition	50%	50%

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**	**Out-of-Network Benefits**
D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8692 - Replacement of lost or broken retainer D8693 - Re-cement or re-bond fixed retainer D8694 - Repair of fixed retainers, includes reattachment 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 D8703 - Replacement of lost or broken retainer - maxillary D8704 - Replacement of lost or broken retainer - mandibular		

The following Procedure Codes are covered under the medical portion of the Policy:

D0290 – Posterior-anterior or lateral skull and facial bone survey film
D0320 – Temporomandibular joint arthrogram, including injection
D0321 – Other temporomandibular joint films, by report
D5992 – Adjust maxillofacial prosthetic appliance, by report
D5993 – Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
2. Procedures that are considered to be Experimental Services, except as specifically provided in the Policy for Approved Clinical Trials.
3. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
4. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through the Policy.
5. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates, except as specifically provided in Section 6: Extension of Benefits after Termination.

6. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
7. Foreign Services are not covered unless required for a Dental Emergency.

Section 4: Claims for Pediatric Dental Services

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

Payment for Dental Services

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

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

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

To file a claim, submit the above information to the Company at the following address:
UnitedHealthcare Dental
ATTN: Claims Unit
P. O. Box 30567
Salt Lake City, UT 84130-0567

If the Insured Person would like to use a claim form, call Customer Service at the number 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 Out-of-Network Benefits, when Covered Dental Services are received from out-of-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 provision.

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

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

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

Dental Services Deductible - the amount the Insured Person must incur for Covered Dental Services in a Policy Year before becoming eligible for dental benefits.

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

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

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

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

Out-of-Network Benefits - benefits available for Covered Dental Services obtained from out-of-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. The Usual and Customary Fee will never be less than the Allowed Dental Amount.

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

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

Section 6: Extension of Benefits After Termination

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

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

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

Section 21: Pediatric Vision Services Benefit

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

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 out-of-Network Benefits unless otherwise specifically stated.

Benefits do not include applicable sales tax charged on Vision Care Services.

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

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

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 but not limited to:

- 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 when professional indicated.

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 chooses 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 chooses 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 chooses 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.
- The prescription of corrective eyewear or vision aids where indicated.
- Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.
- Prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes.

Schedule of Benefits

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $20.	80%
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $40.	80%
• Bifocal		100% after a Copayment of $40.	80%
• Trifocal		100% after a Copayment of $40.	80%
• Lenticular		100% after a Copayment of $40.	80%
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100%
• Standard scratch-resistant coating		100%	100%

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	80%
• Eyeglass frames with a retail cost of $130 - $160.		100% after a Copayment of $15.	80%
• Eyeglass frames with a retail cost of $160 - $200.		100% after a Copayment of $30.	80%
• Eyeglass frames with a retail cost of $200 - $250.		100% after a Copayment of $50.	80%
Vision Care Service	**What is the Frequency of Service?**	**Network Benefit**	**Out-of-Network Benefit**
• Eyeglass frames with a retail cost greater than $250.		60%	50%
Contact Lenses Fitting & Evaluation	Once per year.	100%	80%
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $40.	80%
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	80%

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
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.	Comprehensive low vision exam once every 5 years, including 4 follow-up visits in any 5-year period and prescribed optical devices, such as high-powered spectacles, magnifiers and telescopes.		
• Low vision testing		100%	80%
• Low vision therapy		100%	80%

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Payment for Vision Care Services

To file a claim for reimbursement for Vision Care Services provided by an out-of-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 an out-of-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. Out-of-Network benefits are covered as specified in the Schedule of Benefits

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 5: Extension of Benefits after Termination

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

UnitedHealthcare Insurance Company
Administrative Office Address: P.O. Box 809025
Dallas, TX 753

Schedule of Benefits

University of Maryland - Baltimore

2024-1780-1

METALLIC LEVEL - PLATINUM WITH ACTUARIAL VALUE OF 92.110%

Injury and Sickness Benefits

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

Deductible Preferred Provider	**$100 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network Provider	**$200 (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 Preferred Provider	**$1,500 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Provider	**$3,000 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network Provider	**$5,000 (Per Insured Person, Per Policy Year)**

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

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network Provider Benefits. 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. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays.

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	Allowed Amount after Deductible	Allowed Amount after Deductible
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care See Benefits for Maternity Expenses	Paid as any other Sickness	Paid as any other Sickness

Inpatient	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 maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. (Benefits include surgical treatment of Morbid Obesity. See Benefits for Morbid Obesity.)	Allowed Amount after Deductible	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 maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Registered Nurse's Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	Allowed Amount after Deductible	Allowed Amount after Deductible
Pre-admission Testing	Allowed Amount after Deductible	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 maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures. (Benefits include surgical treatment of Morbid Obesity. See Benefits for Morbid Obesity.)	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount after Deductible	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 maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	$15 Copay per visit 100% of Allowed Amount not subject to Deductible	80% of Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Chiropractic Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Habilitative Services See also Benefits for Habilitative Services for Children.	Allowed Amount after Deductible	Allowed Amount after Deductible
Rehabilitative Services	$40 Copay per visit 100% of Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital. The Out-of-Network Provider cost sharing will be the same as the Preferred Provider cost-sharing. See Out-of-Network Emergency Services on page 4 of the Certificate.	$150 Copay per visit 100% of Allowed Amount after Deductible	$150 Copay per visit 100% of Allowed Amount after Deductible
Diagnostic X-ray Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Tests & Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information. The Insured Person's Copay or Coinsurance will not exceed $150 for up to a 30-day supply for a Specialty Prescription Drug Product dispensed at a Network Pharmacy. In certain circumstances, a pro-rated daily Copayment or Coinsurance amount for a partial supply of a Prescription Drug Product will be available when dispensed by a Network Pharmacy. When a Prescription Drug is classified as a Maintenance Medication according to Maryland law and as written by the Physician. Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug and thereafter, up to a consecutive 90-day supply of a Prescription Drug subject to a Copay per prescription at 2.5 times the Copay for a 31-day supply. The applicable Copay or	*Prescription Drugs from a Retail or Mail-order UnitedHealthcare Pharmacy (UHCP), $20 Copay per prescription Tier 1 $40 Copay per prescription Tier 2 $70 Copay per prescription Tier 3 up to a 31-day supply per prescription after Deductible When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge).	$20 Copay per prescription generic drug $40 Copay per prescription brand-name drug 100% of billed charge up to a 31-day supply per prescription after Deductible

Coinsurance will never be greater than the cost of the Prescription Drug. An Insured Person's Copay or Coinsurance will not exceed the retail price of the Prescription Drug Product. The Insured Person's Copay or Coinsurance will not exceed $150 for up to a 30-day supply for Prescription Drug Products prescribed to treat Diabetes, HIV and AIDS. For insulin drugs, the total amount of Copayments or Coinsurance shall not exceed $30 for an individual prescription of up to a 30-day supply.		

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Durable Medical Equipment	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees	$15 Copay per visit 100% of Allowed Amount not subject to Deductible	80% of Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Allowed Amount after Deductible	Allowed Amount after Deductible
Mental Illness and Substance Use Disorder Treatment	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $15 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs***:* Allowed Amount after Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** 80% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs***:* Allowed Amount after Deductible
Maternity See Benefits for Maternity Expenses. Home visits will not be subject to a Copay, Coinsurance or Deductible.	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Abortion Care Services	100% of Allowed Amount not subject to Deductible	100% of Allowed Amount not subject to Deductible
Preventive Care Services No Deductible or Copays will be applied to Preventive Care Services. 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

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery Following a Mastectomy	100% of Allowed Amount after Deductible	100% of Allowed Amount after Deductible
Diabetes Services	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospice Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Skilled Nursing Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	$25 Copay per visit 100% of Allowed Amount after Deductible	$25 Copay per visit 100% of Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Allergy Treatment	Paid as any other Sickness	Paid as any other Sickness
Cardiac Rehabilitation	Allowed Amount after Deductible	Allowed Amount after Deductible
Case Management Approved Services	Paid as any other Sickness	Paid as any other Sickness
Family Planning See Family Planning Medical Expense Benefit description for additional cost share details.	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids	Allowed Amount after Deductible	Allowed Amount after Deductible
Infertility Services	Paid as any other Sickness	Paid as any other Sickness
Medical Foods	Allowed Amount after Deductible	Allowed Amount after Deductible
Nutritional Services	Paid as any other Sickness	Paid as any other Sickness
Patient Centered Medical Care Coordination	Paid as any other Sickness	Paid as any other Sickness
Pulmonary Rehabilitation	Paid as any other Sickness	Paid as any other Sickness
Wellness Program Benefits	Up to $200 per 6 month period not subject to Deductible	Up to $200 per 6 month period not subject to Deductible
Wigs	Allowed Amount after Deductible	Allowed Amount after Deductible
Fertility Preservation Cryogenic and other preservation techniques when all other fertility services have been exhausted.	Allowed Amount after Deductible	Allowed Amount after Deductible

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

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

When Are Benefits Available for Prescription Drug Products?

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

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

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

The Insured must either show their ID card to the Network Pharmacy when the prescription is filled or provide the Network Pharmacy with identifying information that can be verified by the Company during regular business hours. If the Insured does not show their ID card to the Network Pharmacy or provide verifiable information, they will need to pay for the Prescription Drug at the pharmacy.

The Insured may then submit a reimbursement form along with the paid receipts in order to be reimbursed. Insureds may obtain reimbursement forms by visiting www.uhcsr.com and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

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

When prescriptions are filled at pharmacies outside a Network Pharmacy, the Insured must pay for the Prescription Drugs out of pocket and submit the receipts for reimbursement as described in the How to File a Claim for Injury and Sickness Benefits section in the Certificate of Coverage.

NETWORK PRESCRIPTION DRUG BENEFITS

Copayment and/or Coinsurance Amount

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

- The applicable Copayment and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

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

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

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

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

How Do Supply Limits Apply?

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

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

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

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed , however, this does not apply to Specialty Prescription Drug Pharmaceutical Products or a drug prescribed to treat diabetes, HIV, or AIDS that provide one dose that provides treatment for more than 30-days.

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

Note: Some products are subject to additional supply limits based on criteria that the Company has developed. Supply limits are subject, from time to time, to the Company's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply or may require that a minimum amount be dispensed.

The Insured may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Company at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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

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

Partial Supply of a Prescription Drug Product

The Company will allow and apply a pro-rated daily Copayment or Coinsurance amount for a partial supply of a Prescription Drug Product that is dispensed by a Network Pharmacy if:

- The prescriber or the pharmacist determines dispensing a partial supply of a Prescription Drug Product to be in the Insured's best interest.
- The Prescription Drug Product is anticipated to be required for more than 3 months.
- The Insured Person requests or agrees to a partial supply for the purposes of synchronizing the dispensing of the Insured's Prescription Drug Products.
- The Prescription Drug Product is not a Schedule II controlled dangerous substance.
- The supply and dispensing of the Prescription Drug Product meets all notification requirements specific to the Prescription Drug Product at the time of the synchronized dispensing.

What Happens When a Brand-name Drug Becomes Available as a Generic?

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

What Happens When a Biosimilar Product Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, the Copayment and/or Coinsurance may change or the Insured will no longer have benefits for that particular reference product.

Designated Pharmacies

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

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Specialty Prescription Drug Product from a Designated Pharmacy, the Insured may opt-out of the Designated Pharmacy program at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

If the Insured opts-out of the program and fills their Specialty Prescription Drug Product at a non-Designated Pharmacy but does not inform the Company, the Insured will be responsible for the entire cost of the Specialty Prescription Drug Product.

For a Specialty Prescription Drug Product, if the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge), not to exceed $150 for up to a 30-day supply, based on the applicable tier.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

If the Insured is directed to a Designated Pharmacy and the Insured has informed the Company of their decision not to obtain their Specialty Prescription Drug Product from a Designated Pharmacy, and the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge), not to exceed $150 for up to a 30-day supply, based on the applicable tier.

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

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

Do Notification Requirements Apply?

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

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

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

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

When the Insured submits a claim on this basis, the Insured may pay more because they did not notify the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Out-of-Network Reimbursement Rate (for Prescription Drug Products from an out-of-Network Pharmacy), less the required Copayment and/or Coinsurance and any Deductible that applies.

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

Does Step Therapy Apply?

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. In order to receive benefits for such Prescription Drug Products an Insured must use a different Prescription Drug Product(s) first.

A step therapy requirement will not be imposed if:

- The step therapy drug has not been approved by the U.S. Food and Drug Administration (FDA) for the medical condition being treated; or
- The prescribing provider provides supporting medical information to the Company that a Prescription Drug Product:
  - Was ordered by a prescribing provider for the Insured Person within the past 180 days;
  - Based on the professional judgement of the prescribing provider, was effective in treating the Insured Person's medical condition.
- The Prescription Drug has been approved by the FDA and;
  - Is being used to treat the Insured Person's stage four advanced metastatic cancer; and
  - Use of the Prescription Drug is consistent with the FDA-approved indication of the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and
  - Is supported by peer-reviewed medical literature.

Step Therapy for a Prescription Drug Product is not required when used for the treatment of an opioid use disorder and it contains methadone, buprenorphine or naltrexone.

The Insured may find out whether a Prescription Drug Product is subject to step therapy requirements at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

When Does the Company Limit Selection of Pharmacies?

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's choice of Network Pharmacies may be limited. If this happens, the Company may require the Insured to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Network benefits will be paid only if the Insured uses the chosen Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will choose a Network Pharmacy for the Insured. If the Insured does not use the designated single Network Pharmacy, the benefits will be provided under the out-of-network prescription drug benefit.

Coverage Policies and Guidelines

The Company's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Company's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include review of the place in therapy or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per calendar year. If a drug is removed from the PDL or moved to a higher tier, notice will be provided at least 30 days prior to this change becoming effective.
When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

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

Rebates and Other Payments

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

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

Definitions

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

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician will be classified as Brand-name by the Company.

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

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are a Designated Pharmacy.

Experimental Services means medical, dental, 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 are not recognized as efficacious as the term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental services do not include Approved Clinical Trials as specifically provided for in the Policy.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician will be classified as a Generic by the Company.

Maintenance Medication means a Prescription Drug Product expected to be used for six months or more to treat or prevent a chronic condition. The Insured may find out if a Prescription Drug Product is a Maintenance Medication at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

Network Pharmacy means a pharmacy that has:

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

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

- The date it is placed on a tier by the Company's PDL Management Committee.
- December 31st of the following calendar year.

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

Out-of-Network Pharmacy means a pharmacy that has not been designated by the Company as a Network Pharmacy.

Out-of-Network Reimbursement Rate means the amount the Company will pay to reimburse an Insured for a Prescription Drug Product that is dispensed at an out-of-Network Pharmacy. The Out-of-Network Reimbursement Rate for a particular Prescription Drug Product dispensed at an out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax.

PPACA means Patient Protection and Affordable Care Act of 2010.

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

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

The Insured may find out if a drug is a PPACA Zero Cost Share Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

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

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

Prescription Drug List means a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's review and change from time to time. The Insured may find out which tier a particular Prescription Drug Product has been placed at www.uhcsr.com or call *Customer Service* at 1-855-828-7716.

Prescription Drug List (PDL) Management Committee means the committee that the Company designates for placing Prescription Drugs into specific tiers.

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

- Inhalers (with spacers).

- Insulin.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered at a Network Pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters, including continuous glucose monitors.

Prescription Order or Refill means the directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Specialty Prescription Drug Product means Prescription Drug Products that are prescribed for an Insured with a complex, chronic or rare medical condition that costs $600 or more for up to a 30-day supply, is not typically stocked at a retail pharmacy and requires a difficult or unusual process of delivery to the patient in the preparation, handling, storage, inventory, or distribution of the drug. These Prescription Drug Products require enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. Insured Persons may access a complete list of Specialty Prescription Drug Products at www.uhcsr.com or call *Customer Service* at 1-855-828-7716.

Specialty Prescription Drug Product does not include a Prescription Drug Product prescribed to treat Diabetes, HIV or AIDS.

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

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

Additional Exclusions

In addition to the Exclusions and Limitations shown in the Certificate of Coverage, the following Exclusions apply:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for a Medical Emergency.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
5. Experimental Services and medications used for Experimental Services for certain diseases except as specifically provided in the Policy for Approved Clinical Trials.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
9. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
10. Certain unit dose packaging or repackagers of Prescription Drug Products.
11. Medications used for cosmetic or convenience purposes.
12. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)
13. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as

if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician . Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to FDA approved over-the-counter contraceptives that do not require a prescription. Please access www.uhcsr.com or call *Customer Service* at 1-855-828-7716 for more information on which over-the-counter drugs are excluded.

14. Note: Notwithstanding this exclusion, we will provide immediate coverage for excluded Prescription Drug Products described above if, in the judgement of the Authorized Prescriber:
    - The over-the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or
    - An equivalent over-the-counter drug:
        - Has been ineffective in treating the Insured's disease or condition; or
        - Has caused or is likely to cause an adverse reaction or other harm to the Insured.
15. Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
16. Prescription Drug Products not included on Tier – 1 ,2 , or 3 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. Please access www.uhcsr.com or call *Customer Service* at 1-855-828-7716 for more information for Prescription Drug Products not included on Tier – 1 ,2 , or 3 of the Prescription Drug List.
    Note: We will provide immediate coverage for a Prescription Drug Product if, in the judgement of the Authorized Prescriber:
    - There is no equivalent Prescription Drug Product on Tier – 1 ,2 , or 3 of the Prescription Drug List; or
    - An equivalent Prescription Drug Product on Tier – 1 ,2 , or 3 of the Prescription Drug List:
        - Has been ineffective in treating the Insured Person's disease or condition; or
        - Has caused or is likely to cause an adverse reaction or other harm to the Insured Person.
17. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision. Please access www.uhcsr.com or call *Customer Service* at 1-855-828-7716 for more information on which Prescription Drug Products are classified as Therapeutically Equivalent.
    Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgement of the Authorized Prescriber:
    - The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
    - The covered Prescription Drug Product on the Prescription Drug List:
        - Has been ineffective in treating the Insured Person's disease or condition; or
        - Has caused or is likely to cause an adverse reaction or other harm to the Insured Person.
18. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision. Please access www.uhcsr.com or call *Customer Service* at 1-855-828-7716 for more information on which Prescription Drug Products are classified as Therapeutically Equivalent.
    Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgement of the Authorized Prescriber:
    - The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
    - The covered Prescription Drug Product on the Prescription Drug List:
        - Has been ineffective in treating the Insured Person's disease or condition; or
        - Has caused or is likely to cause an adverse reaction or other harm to the Insured Person.
19. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision. Please access www.uhcsr.com or call *Customer Service* at 1-855-828-7716 for more information on which Prescription Drug Products are classified as Therapeutically Equivalent.
    Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgement of the Authorized Prescriber:
    - The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
    - The covered Prescription Drug Product on the Prescription Drug List:
        - Has been ineffective in treating the Insured Person's disease or condition; or
        - Has caused or is likely to cause an adverse reaction or other harm to the Insured Person.

20. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.

    For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

    Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision. Please access www.uhcsr.com or call *Customer Service* at 1-855-828-7716 for more information on which Prescription Drug Products are classified as Therapeutically Equivalent.

    Note: We will provide immediate coverage for a Prescription Drug Product deemed Therapeutically Equivalent if, in the judgement of the Authorized Prescriber:
    - The excluded Prescription Drug Product is not Therapeutically Equivalent to the other covered Prescription Drug Product; or
    - The covered Prescription Drug Product on the Prescription Drug List:
        - Has been ineffective in treating the Insured Person's disease or condition; or
        - Has caused or is likely to cause an adverse reaction or other harm to the Insured Person.
21. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
22. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
23. Diagnostic kits and products, including associated services.
24. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
25. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
26. A Prescription Drug Product that contains marijuana, including medical marijuana.
27. Any product dispensed solely for the purpose of appetite suppression or weight loss.

Right to Request an Exclusion Exception

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

Please note, if the request for an exception is approved, the Insured may be responsible for paying the applicable Copayment and/or Coinsurance based on the Prescription Drug Product tier placement, or at the highest tier as described in the Schedule of Benefits.

Urgent Requests

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

External Review

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

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling

1-800-505-4160 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

OUT-OF-NETWORK PRESCRIPTION DRUG BENEFITS

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

Copayment and/or Coinsurance Amount
For Prescription Drug Products at an Out-of-Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The prescription drug cost for that Prescription Drug Product.

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

- The applicable Copayment and/or Coinsurance; or
- The prescription drug cost for that Prescription Drug Product.

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

Supply Limits

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

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

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

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed, however, this does not apply to Specialty Prescription Drug Pharmaceutical Products or a drug prescribed to treat diabetes, HIV, or AIDS that provide one dose that provides treatment for more than 30-days.

When prescriptions are filled at pharmacies outside a Network Pharmacy, the Insured must pay for the Prescription Drugs out of pocket and submit the receipts for reimbursement as described in the How to File a Claim for Injury and Sickness Benefits section in the Certificate of Coverage.

UNITEDHEALTHCARE INSURANCE COMPANY
POLICY ENDORSEMENT

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

President

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

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

Domestic Students, insured spouse, Domestic Partner and insured minor child(ren) are eligible for Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program.

Assistance and Evacuation Benefits

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. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
5. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
6. Medical Evacuations directly or indirectly related to a natural disaster.
7. 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.

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.

NON-DISCRIMINATION NOTICE

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

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

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

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

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

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

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

Complaint forms are available at: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/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.

LANGUAGE ASSISTANCE PROGRAM

We 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 toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee
ᏕᏬᏂᏯᏍᏗ ᎤᎾᏓᏡᎬᏗ ᎤᎾᏓᏛᎬᎢ ᏂᎯ ᎡᏍᎦᏉᏍᏗᏓᏗᏱᎢ ᏂᏓᎬᎶᏛᏅ ᎠᏐᏫᎢ. ᏰᎶᏬ ᎠᏂ ᏫᏴᎳᏫᏕ 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla ho chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole
Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

Hawaiian
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo
Enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen
ကျိာ်တၢ်မၤစၢၤအကိၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိၣ်ဟ့ၣ်အပ့ၤဘၣ်(ခီလီ)န့ၣ်လီၤ. ဝံသးစူၤဆဲးကျိးဘၣ်1-866-260-2723တက့ၢ်.

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خزمەتەکانی یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

Laotian
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeḷọk wōṇāān. Jouj im kaḷḷọk 1-866-260-2723.

Micronesian- Pohnpeian
Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shǫǫdí kohjį' 1-866-260-2723 hodíilnih.

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cɔl 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde
E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

Swahili
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
ܚܕܡܬܐ ܕܗܝܪܐ ܕܠܫܢܐ، ܡܬܛܝܒܐ، ܐܝܠܗ ܩܕܝܟ ܡ̈ܠܝܬܐ. ܩܘܒܠܝ ܠܗ ܢܡܒܪ 1-866-260-2723.

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข
1-866-260-2733

Tongan- Fakatonga
'Oku 'i ai pē 'a e sēvesi ki he lea' ke tokoni kiate koe pea 'oku 'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

Ukrainian
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish
שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ́ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.