



HPHC INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Students of

University of Maine System

University of Maine at Machias
University of Maine at Presque Isle
University of Maine Farmington
University of Southern Maine
University of Maine Orono

2022-2023

This Certificate of Coverage is Part of Policy # 2022-200202-1

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

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

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

Coverage underwritten by HPHC Insurance Company, Inc.,
an affiliate of Harvard Pilgrim Health Care, Inc., and administered
by UnitedHealthcare **StudentResources**

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Introduction

Welcome to the HPHC Insurance Company Student Health Insurance Plan. This plan is underwritten by HPHC 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 1-866-948-8472. The Insured can also write to the Company at:

HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025

Section 1: Who Is Covered

The Master Policy covers students 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 undergraduate students taking 9 or more credit hours per semester and graduate students taking 6 or more credit hours per semester may enroll in this plan on a voluntary basis.

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.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2022. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., July 31, 2023. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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 were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 6 months after the Termination Date.

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

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

Section 4: Pre-Admission Notification

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

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

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

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

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

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

Preferred Providers in the local school area are:

HPHC Insurance Company Network

Preferred Provider Hospitals include HPHC Insurance Company Network.

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 1-866-948-8472 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 at 1-866-948-8472 and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com.

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

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-866-948-8472 to find out if they are eligible for continuity of care benefits.

Insured Persons have the right to choose their own primary care Physician.

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

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

The Company will pay Covered Medical Expenses according to the benefits set forth in the Schedule of Benefits.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid.

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

Preferred Provider Benefits

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

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

Out-of-Network Provider Benefits

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.

This does not apply to:

1. Surprise Bills as defined below.
2. Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians.
3. 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.
4. Out-of-Network Emergency Services as described below.
5. 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.
6. Screening and testing for COVID-19 and administration of COVID-19 vaccine.

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.

Protection from Surprise Bills and Bills for Out-of-Network Emergency Services

“Surprise bill” means a bill for Covered Medical Expenses, including, but not limited to, Emergency Services, received by an Insured for services rendered by an Out-of-Network Provider at a Preferred Provider facility:

- During a service or procedure performed by a Preferred Provider.
- During a service or procedure previously approved or authorized by the Company and the Insured did not knowingly elect to obtain such services from the Out-of-Network provider.

A Surprise Bill does not include a bill for Covered Medical Expenses received by an Insured when a Preferred Provider was available to render such services and the Insured Knowingly Elected to Obtain Services from an Out-of-Network provider.

“Knowingly elected to obtain services from an Out-of-Network provider” means that an Insured Person chose the services of a specific provider, with full knowledge that the provider is an Out-of-Network Provider, under circumstances that indicate that the Insured Person had and was informed of the opportunity to receive services from a Preferred Provider but instead selected the Out-of-Network Provider. The disclosure by a provider of their network status does not render an Insured’s decision to proceed with treatment from that provider a choice made knowingly.

With respect to a Surprise Bill or a bill for covered Emergency Services rendered by an Out-of-Network Provider:

- The Company will require an Insured to pay only the applicable Coinsurance, Copayment, Deductible or other out-of-pocket expense that would be imposed for Covered Medical Expenses if services were rendered by a Preferred Provider. If the Insured Person is subject to Coinsurance, the Company will calculate the Coinsurance amount based on the Allowed Amount for that Covered Medical Expense.

Except as specifically provided below for ambulance services, unless the Company and Out-of-Network Provider agree otherwise, the Company will reimburse the Out-of-Network Provider or Insured, as applicable, for Covered Medical Expenses rendered at the greater of:

- The Company's Recognized Amount paid for that Covered Medical Expense by a similar provider in the Insured's geographic area.
- The Recognized Amount paid by all Insurance carriers for that Covered Medical Expense by a similar provider in the Insured's geographic area as determined by the all payer claims database maintained by the Maine Health Data Organization or if Maine Health Data Organization claims data is insufficient or otherwise inapplicable, another independent medical claims database.

The Company will reimburse an Out-of-Network Provider for ambulance services that are covered Emergency Services at the Out-of-Network Provider's rate or at 180% of the Medicare rate for that service, whichever is less, unless the Company and Out-of-Network Provider agree otherwise. The Company will reimburse a Preferred Provider for ambulance services that are covered Emergency Services at the Preferred Provider's rate or 200% of the Medicare rate, whichever is less. Preferred Provider and Out-of-Network ambulance service providers located in rural or super rural areas who are eligible for additional Medicare reimbursement will be supplemented by an additional reimbursement equal to the additional reimbursement that would be provided to Medicare enrollees. The Insured Person will only be required to pay the applicable Coinsurance, Copayment and Deductible that would be imposed if the ambulance service were rendered by a Preferred Provider.

Any disputes for a Surprise Bill and bills for Out-of-Network Emergency Services may be resolved through the independent dispute resolution process established by the Maine Superintendent of Insurance.

Emergency Services received by an Out-of-Network Provider in an emergency facility or setting will be covered at the same Deductible, Copayment or Coinsurance that would apply if such services were provided by a Preferred Provider. Any payment made by the Insured Person for such covered Emergency Services received by an Out-of-Network Provider will be applied to the Insured Person's Preferred Provider cost sharing limit. If the Insured Person has paid their share of the charge as specified in the Policy for services received by a Preferred Provider, the Company will hold the Insured harmless from any additional amount owed to an Out-of-Network Provider for covered Emergency Services and will make payment to the Out-of-Network Provider as specified above.

An Out-of-Network Provider reimbursed for a Surprise Bill or a bill for covered Emergency Services, as specified above, may not bill an Insured for Covered Medical Expenses beyond the applicable Coinsurance, Copayment, Deductible or other out-of-pocket expense that would be imposed for Covered Medical Expenses if the services were rendered by a Preferred Provider under the Policy.

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. See also Benefits for Telehealth Services.

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.**

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.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**

While Hospital Confined and routine nursery care provided immediately after birth.

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

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

If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames. No Deductible, Copayment or Coinsurance is applied for benefits provided for the newborn baby. Newborn care does not include any services provided after the mother has been discharged from the Hospital.

5. **Surgery.**

Physician's fees for Inpatient surgery.

6. **Assistant Surgeon Fees.**

Assistant Surgeon Fees in connection with Inpatient surgery.

7. **Anesthetist Services.**

Professional services administered in connection with Inpatient surgery.

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

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

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

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

9. **Physician's Visits.**

Non-surgical Physician services when confined as an Inpatient.

10. **Pre-admission Testing.**

Benefits are limited to routine tests such as:

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

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

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

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.
12. **Day Surgery Miscellaneous.**
Facility charge and the charge for services and supplies in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.
13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery.
14. **Anesthetist Services.**
Professional services administered in connection with outpatient surgery.
15. **Physician's Visits.**
Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to surgery or Physiotherapy.

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

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):
 - Physical therapy.
 - Occupational therapy.
 - Cardiac rehabilitation therapy.
 - Manipulative treatment.
 - Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules.

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

17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
 - The facility charge for use of the emergency room and supplies.

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

18. **Diagnostic X-ray Services.**
Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services. Benefits for Diagnostic X-ray Services include diagnostic services provided by freestanding imaging centers when ordered by a Physician.
19. **Radiation Therapy.**
See Schedule of Benefits.

20. **Laboratory Procedures.**

Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services. Benefits for Laboratory Procedures include diagnostic services provided by freestanding imaging centers when ordered by a Physician.

21. **Tests and Procedures.**

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

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

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

- Inhalation therapy.
- Infusion therapy. (Medical supplies and equipment needed to appropriately administer infusion therapy will be paid under the medical expense benefit for Medical Supplies.)
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.

Benefits for Tests and Procedures include services performed at freestanding imaging centers, independent laboratories, licensed infusion therapy facilities, and ambulatory infusion centers when ordered by a Physician. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections.**

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

23. **Chemotherapy.**

See Schedule of Benefits.

24. **Prescription Drugs.**

See Schedule of Benefits.

Benefits will not be denied for a prescribed drug or medical device on the basis that the use of the drug or device is investigational if the intended use of the drug or device is included in the labeling authorized by the federal Food and Drug Administration (FDA) or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

Benefits for prescription eye drops will be provided without regard to a coverage restriction for early refill of prescription renewals as long as the following criteria are met:

- The Insured Person requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing Physician have elapsed.
- The prescribing Physician indicated on the original prescription that a specific number of refills are authorized.
- The refill requested by the Insured Person does not exceed the number of refills indicated on the original prescription.
- The prescription has not been refilled more than once during the period authorized by the prescribing Physician prior to the request for an early refill.
- The prescription eye drops are a covered benefit under the Policy.

Other

25. **Ambulance Services.**

See Schedule of Benefits.

26. **Durable Medical Equipment.**

Durable Medical Equipment must be all of the following:

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

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

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices that straighten or change the shape of a body part.

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

See also Benefits for Prosthetic Devices.

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

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

- Injury to Sound, Natural Teeth.
- Removal of impacted or unerupted teeth in a non-Hospital setting.

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

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

29. **Mental Illness Treatment.**
See Benefits for Mental Illness and Substance Use Disorder.

30. **Substance Use Disorder Treatment.**
See Benefits for Mental Illness and Substance Use Disorder.

31. **Maternity.**
Same as any other Sickness.

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

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

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. Benefits are provided to both married and unmarried women.

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

33. **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* or equivalent rating from a successor organization.
- Immunizations that have in effect a recommendation from the federal Department of Health and Human Services, Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices and that are consistent with the recommendations of the *American Academy of Pediatrics*, the *American Academy of Family Physicians* or the *American College of Obstetricians and Gynecologists* or a successor organization.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal *Department of Health and Human Services, Health Resources and Services Administration* that are consistent with the recommendations of the *American Academy of Pediatrics* or a successor organization.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the federal *Department of Health and Human Services, Health Resources and Services Administration* women's preventive services guidelines that are consistent with the recommendation of the *American College of Obstetricians and Gynecologists* women's preventive services initiative.

Please note: The Policy will cover certain Preventive Care Services with no cost sharing to the Insured Person when the services are received from a Preferred Provider. If the primary purpose for an office visit is for the delivery of Preventive Care Services and the services are billed together with the office visit, no Insured Person cost sharing will be applied. If a Preventive Care Service is billed separately from an office visit, the Insured Person will be subject to cost sharing for the office visit. If the primary purpose for the office visit is for something other than the delivery of Preventive Care Services, Insured Person cost-sharing will be applied to the office visit and services that are not Preventive Care Services.

34. **Reconstructive Breast Surgery Following Mastectomy.**

Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery.

35. **Diabetes Services.**

Same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes Treatment.

36. **Home Health Care.**

See Benefits for Home Health Care

37. **Hospice Care.**

See Benefits for Hospice Care Services.

38. **Inpatient Rehabilitation Facility.**

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

39. **Skilled Nursing Facility.**

Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:

- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

40. **Urgent Care Center.**

Benefits are limited to:

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

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

41. **Hospital Outpatient Facility or Clinic.**

Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

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

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

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

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

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

- 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.

See also Benefits for Clinical Trials.

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.

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

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

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

44. Pediatric Dental and Vision Services.

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

45. Educational Services.

Benefits are limited to asthma education programs for Insureds with asthma and their families. Benefits are provided when the program is received from an approved Preferred Provider.

46. **Massage Therapy.**
Benefits for massage therapy are payable when services are provided as part of an active course of treatment and performed by a Physician. Benefits are not included for services performed by a massage therapist.
47. **Medical Supplies.**
Medical supplies must be furnished by a provider in the course of delivering services for a covered Injury or Sickness.
Benefits are limited to a 31-day supply per purchase.
48. **Smoking Cessation.**
Benefits are paid as any other Sickness for nicotine replacement therapy products and any other medication specifically approved by the FDA for smoking cessation when prescribed by the Insured's Physician. Benefits include smoking cessation education and counseling programs.

Section 7: Mandated Benefits

BENEFITS FOR ANNUAL GYNECOLOGICAL EXAMINATION AND PAP TEST

Benefits will be provided for an annual gynecological examination including routine pelvic and clinical breast examinations. Benefits will also be provided for screening Pap tests recommended by a Physician.

Gynecological examinations and pap tests covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services benefit listed in the Schedule.

All other gynecological examinations and pap tests will be paid the same as any other Sickness and be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR BREAST CANCER TREATMENT AND RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness for breast cancer treatment and post-mastectomy reconstruction.

Coverage for the treatment of breast cancer shall be provided for a period of time determined by the attending Physician, in consultation with the patient, to be Medically Necessary following a mastectomy, a lumpectomy or a lymph node dissection.

Post mastectomy reconstruction includes the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the Insured elects reconstruction and in the manner chosen by the Insured and the Physician.

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

BENEFITS FOR MAMMOGRAM

Benefits will be provided for screening mammograms performed by Physicians that meet the standards established by the Department of Human Services rules relating to radiation protection. A screening mammogram also includes an additional radiological procedure recommended by a Physician when the results of an initial radiologic procedure are not definitive. Benefits will be provided for screening mammograms performed at least once a year for Insureds 40 years of age and over.

Screening mammograms covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services benefit listed in the Schedule.

All other screening mammograms will be paid the same as any other Sickness and be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for Services for the Early Detection of Prostate Cancer.

Services for the early detection of prostate cancer means the following procedures provided to a man for the purpose of early detection of prostate cancer:

1. A digital rectal examination.

2. A prostate-specific antigen test.

Benefits shall be provided for services for the early detection of prostate cancer, if recommended by a Physician, at least once a year for Insureds 50 years of age or older until an Insured reaches the age of 72.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for Services for Colorectal Cancer Screening for asymptomatic Insured's who are:

1. At average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.
2. At high risk for colorectal cancer.

"Colorectal Cancer Screening" means a colorectal cancer examinations and laboratory tests recommended by a Physician in accordance with the most recently published colorectal cancer screening guidelines of the National Cancer Society.

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

BENEFITS FOR CHIROPRACTIC SERVICES

Benefits will be paid the same as any other Sickness for services performed by a chiropractor to the extent that services are within the lawful scope of practice of a chiropractor licensed to practice in Maine. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

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

BENEFITS FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the Medically Necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if:

1. The Insured's treating Physician or a Physician who specializes in the treatment of diabetes certifies that the equipment and services are necessary.
2. The diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.

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

BENEFITS FOR MODIFIED LOW-PROTEIN FOOD PRODUCT

Benefits will be paid the same as any other Sickness for metabolic formula and Special Modified Low-Protein Food Products that have been prescribed by a licensed Physician for a person with an Inborn Error of Metabolism. Benefits shall be provided for metabolic formula and Special Modified Low-Protein Food Products.

Inborn error of metabolism means a genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life. Special modified low-protein food product means food formulated to reduce the protein content to less than one gram of protein per serving and does not include foods naturally low in protein.

Benefits will include the supplies and equipment for appropriate administration.

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

BENEFITS FOR CONTRACEPTIVES

Benefits will be paid the same as any other Prescription Drugs for all prescription Contraceptive Supplies approved by the federal Food and Drug Administration. In addition, benefits will be paid the same as any other Sickness for Outpatient Contraceptive Services provided by a Physician. This benefit does not apply to prescription drugs or devices that are designed to terminate a pregnancy.

Benefits include up to a 12 month supply of prescribed Contraceptive Supplies. At the discretion of the prescribing healthcare provider, the Contraceptive Supplies may be furnished or dispensed all at once or over the course of the 12 months.

“Contraceptive supply/supplies” means all contraceptive drugs, devices and products approved by the Federal Food and Drug Administration to prevent an unwanted pregnancy.

“Outpatient contraceptive services” means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent an unintended pregnancy.

Contraceptive Supplies and Outpatient Contraceptive Services covered by the Preventive Care Services benefit and received from a Preferred Provider will be covered with no cost share as referenced in the Preventive Care Services benefit listed in the Schedule of Benefits. Benefits will be provided for at least one Contraceptive Supply within each method of contraception. If the Insured’s Physician recommends a particular Contraceptive Supply based on a determination of Medical Necessity, the Company will provide benefits without cost sharing for the prescribed Contraceptive Supply.

All other Contraceptive Supplies and Outpatient Contraceptive Services covered by this benefit shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDER

Benefits will be paid for Mental Illness and Substance Use Disorder as specified in the Policy Schedule of Benefits.

Benefits for Mental Illness include the following: Inpatient care; Day treatment services; Outpatient services; Home health care services.

Mental illness shall include the following categories as defined in the *Diagnostic and Statistical Manual*, except for those that are designated as “V” codes by the *Diagnostic and Statistical Manual*:

1. Psychotic disorders, including schizophrenia.
2. Dissociative disorders.
3. Mood disorders.
4. Anxiety disorders.
5. Personality disorders.
6. Paraphilias.
7. Attention deficit and disruptive behavior disorders.
8. Pervasive development disorders.
9. Tic disorders.
10. Eating disorders, including bulimia and anorexia.
11. Substance use disorders.

Benefits for Substance Use Disorder include residential treatment at a Hospital or free-standing residential treatment center which is licensed, certified or approved by the State; and outpatient care rendered by state licensed, certified or approved providers.

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

BENEFITS FOR CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for Routine Patient Costs in connection with participation in an Approved Clinical Trial.

Qualified Insured: An Insured is eligible for coverage for participation in an Approved Clinical Trial if the Insured meets the following conditions:

1. The Insured has a life-threatening Sickness for which no standard treatment is effective.
2. The Insured is eligible to participate according to the clinical trial protocol with respect to treatment of such Sickness.
3. The Insured's participation in the trial offers meaningful potential for significant clinical benefit to the Insured.
4. The Insured's referring Physician has concluded that the Insured's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.

"Approved clinical trial," means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.

"Routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.

In the case of Covered Medical Expenses, the Company shall pay Participating Providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by Participating Providers.

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

BENEFITS FOR HOME HEALTH CARE

Benefits will be paid the same as any other Sickness for Home Health Care Services by a Home Health Care Provider.

Each visit by an individual member of a Home Health Care Provider shall be considered as one home care visit. There is no requirement that hospitalization be an antecedent to coverage under the Policy.

Home Health Care Services shall include:

1. Visits by a Registered Nurse or licensed practical nurse to carry out treatments prescribed, or supportive nursing care and observation as indicated.
2. A Physician's home or office visits or both.
3. Visits by a registered physical, speech, occupational, home infusion, inhalation or dietary therapist for services or for evaluation of, consultation with and instruction of nurses in carrying out such therapy prescribed by the attending Physician, or both.
4. Any prescribed laboratory tests and x-ray examination using Hospital or community facilities, drugs, dressings, oxygen or medical appliances and equipment as prescribed by a Physician, but only to the extent that such charges would have been covered under the contract if the Insured had remained in the Hospital.
5. Visits by persons who have completed a home health aide training course under the supervision of a Registered Nurse for the purpose of giving personal care to the patient and performing light household tasks as required by the plan of care, but not including services.

Home health care services means those health care services rendered in the Insured's place of residence on a part-time basis to an Insured Person only if:

1. Hospitalization or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, 42 U.S.C. 1395, et seq., would otherwise have been required if home health care was not provided.
2. The plan covering the home health services is established as prescribed in writing by a Physician.

Home health care provider means a home health care agency which is certified under Title XVIII of the Social Security Act of 1965, as amended, which is all of the following:

1. Is primarily engaged in and licensed or certified to provide skilled nursing and other therapeutic services.
2. Has standards, policies and rules established by a professional group, associated with the agency or organization, which professional group must include at least one Physician and one Registered Nurse.
3. Is available to provide the care needed in the home 7 days a week and has telephone answering service available 24 hours per day.
4. Has the ability to and does provide, either directly or through contract, the services of a coordinator responsible for case discovery and planning and assuring that the covered person receives the services ordered by the Physician.
5. Has under contract the services of a Physician-advisor licensed by the State or a Physician.
6. Conducts periodic case conferences for the purpose of individualized patient care planning and utilization review.
7. Maintains a complete medical record on each patient.

No payment shall be made for services provided by a person who resides in the Insured's residence or who is a member of the Insured's family.

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

BENEFITS FOR HOSPICE CARE SERVICES

Benefits will be paid the same as any Sickness for Hospice Care Services to an Insured who is Terminally Ill.

Hospice Care Services must be provided according to a written care delivery plan developed by a hospice care provider and the recipient of Hospice Care Services. Coverage for Hospice Care Services will be provided whether the services are provided in a home setting or an inpatient setting.

"Hospice care services" means services provided on a 24-hours-a-day, 7-days-a-week basis to an Insured who is terminally ill and that Insured's family. Hospice care services includes, but is not limited to, Physician services; nursing care; respite care; medical and social work services; counseling services; nutritional counseling; pain and symptom management; medical supplies and durable medical equipment; occupational, physical or speech therapies; volunteer services; home health care services; and bereavement services.

"Terminally ill" means an Insured that has a medical prognosis that the life expectancy is 12 months or less if the Sickness runs its normal course.

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

BENEFITS FOR GENERAL ANESTHESIA FOR DENTISTRY

Benefits will be paid the same as any Sickness for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the clinical status or underlying medical condition of an Insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital.

This section applies only to general anesthesia and associated facility charges for only the following Insureds:

1. Insureds, including infants, exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result.
2. Insureds demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
3. Extremely uncooperative, fearful, anxious or uncommunicative children or adolescents with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
4. Insureds who have sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.

This does not include benefits for any charges for the dental procedure itself, other than specifically provided for in the Schedule of Benefits, including, but not limited to, the professional fee of the dentist.

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

BENEFITS FOR PROSTHETIC DEVICES

Benefits will be paid the same as any Sickness for Prosthetic Devices determined by the Insured's Physician to be the most appropriate model that adequately meets the medical needs of the Insured. Benefits will include repair and replacement of a Prosthetic Device if the Insured's Physician determines such repair or replacement appropriate.

Prosthetic Device means an artificial device to replace, in whole or in part, an arm or a leg.

No coverage will be provided for a Prosthetic Device that is designed exclusively for athletic purposes.

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

BENEFITS FOR OFF-LABEL DRUG USE

Benefits will be paid the same as any other Prescription Drug, including Medically Necessary services associated with the administration of such drugs, for the Off-Label Use of Prescription Drugs for the treatment of cancer or HIV/AIDS.

Benefits will not be denied for Prescription Drugs under this provision based on Medical Necessity, unless such denial is unrelated to the legal status of the drug's use. Benefits will not be paid for Prescription Drugs under this provision where the use is contraindicated by the federal Food and drug Administration.

"Off-Label Use" means the use of a federal Food and Drug Administration approved drug for indications other than those stated in labeling that it has approved. The drug need not have been approved for the treatment of cancer or of HIV/AIDS if the use of such drug is supported by one or more citations in (a) the United States Pharmacopeia Drug Information or its successors; (b) the American Hospital Formulary Service Drug Information or its successors; or (c) Peer-reviewed Medical Literature.

"Peer-reviewed Medical Literature" means scientific studies published in at least 2 articles from major peer-reviewed medical journals. These articles must present evidence that supports the Off-Label Use as generally safe and effective.

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

BENEFITS FOR HEARING AIDS

Benefits will be provided for the purchase of a Hearing Aid for each hearing-impaired ear for an Insured Person. The hearing loss must be documented by a Physician or audiologist. The Hearing Aid must be purchased in accordance with federal and state laws, regulations and rules for the sale and dispensing of hearing aids. Benefits are limited to one (1) Hearing Aid for each hearing-impaired ear every 36 months.

"Hearing Aid" means a non-experimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, excluding batteries and cords and other assistive listening devices, including, but not limited to, frequency modulation systems.

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

BENEFITS FOR CARDIAC REHABILITATION

Benefits will be paid the same as any other Sickness for Cardiac Rehabilitation. "Cardiac rehabilitation" means multidisciplinary, Medically Necessary treatment of Insureds with documented cardiovascular disease, which shall be provided in either a Hospital or other setting. That treatment shall include outpatient treatment which is initiated within 26 weeks after the diagnosis of that disease and Physician-recommended continuance of Phase II rehabilitation services in a Hospital or community-based setting and Phase III sessions in a community-based setting.

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

BENEFITS FOR HUMAN LEUKOCYTE ANTIGEN TESTING

Benefits will be paid the same as any other Sickness for human leukocyte antigen testing that is necessary to establish bone marrow transplant donor suitability. Benefits will be limited to one such testing per lifetime.

The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a. The Insured must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization. The Insured must also complete and sign an informed consent form which authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

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

BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

Benefits will be paid for prescribed, orally administered anticancer medications prescribed for cancer treatment used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications.

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

BENEFITS FOR AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Mental Illness for the diagnosis and treatment of Autism Spectrum Disorders in accordance with the following.

Benefits include:

1. Any assessments, evaluations or tests by a Physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder; and
2. Treatment of Autism Spectrum Disorders when determined by a Physician or licensed psychologist that the treatment is a Medical Necessity. A Physician or licensed psychologist may be required to demonstrate ongoing Medical Necessity for benefits provided under this section at least annually.

"Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

"Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition*, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

"Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

1. Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;
2. Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and
3. Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

The number of visits for the treatment of Autism Spectrum Disorder may not be limited. Benefits for Prescription Drugs for the treatment of Autism Spectrum Disorders will be determined in the same manner as benefits for Prescription Drugs for the treatment of any other Sickness.

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.
- The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
- 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. **Active/Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
 6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - 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.
 7. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

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

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

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

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

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

This Coordination of Benefits provision is subject to all of the terms and conditions of the Policy not inconsistent therewith.

Section 9: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

For Loss Of

Life	\$10,000.00
Both Hands, Both Feet, or Sight of Both Eyes	\$10,000.00
One Hand and One Foot	\$5,000.00
Either One Hand or One Foot and Sight of One Eye	\$2,500.00
One Hand or One Foot or Sight of One Eye	\$2,500.00
Entire Thumb and Index Finger of Either Hand	\$2,500.00

Loss shall mean with regard to hands and feet, 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.

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

Section 10: Definitions

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

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

Allowed amounts are based on the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

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

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

1. An appropriate medical screening examination that is within the capability of an emergency department of a Hospital or an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate and treat an emergency medical condition.
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

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

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

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

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

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

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

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

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

INJURY means bodily injury which is all of the following:

1. Directly and independently caused by specific accidental contact with another body or object.
1. 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 injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease. Covered Medical Expenses incurred as a result of an injury that occurred prior to the Policy's Effective Date will be considered a Sickness under the Policy.

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

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

INSURED PERSON means: 1) the Named Insured. The term Insured also means Insured Person.

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

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

MEDICAL EMERGENCY means, regardless of the final diagnosis given, a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including 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 physical or mental 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 pregnant woman or unborn child.
5. In the case of a pregnant woman who is having contractions, that there is:
 - a. Inadequate time to effect a safe transfer of the woman to another Hospital before delivery; or

- b. A treat to the health or safety of the woman or unborn child if the woman were to be transferred to another Hospital.

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

MEDICAL NECESSITY/MEDICALLY NECESSARY means health care services or products provided to an Insured for the purpose of preventing, diagnosing or treating an Injury or Sickness or the symptoms of an Injury or Sickness in a manner that is:

1. Consistent with generally accepted standards of medical practice.
2. Clinically appropriate in terms of type, frequency, extent, site and duration.
3. Demonstrated through scientific evidence to be effective in improving health outcomes.
4. Representative of "best practices" in the medical profession.
5. Not primarily for the convenience of the Insured, or the Insured's Physician.

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

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

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

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

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the 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 defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. A Physician defined under the Policy includes, but is not limited to, a certified nurse practitioner, certified midwife, certified nurse midwife, clinical counseling professionals, psychologist, psychiatric nurses, dentist, independent practice dental hygienists, dental hygiene therapist, registered nurse first assistant and social workers.

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

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

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

1. The Policy.
2. The Policyholder Application.
3. The Certificate of Coverage.

4. The Schedule of Benefits.
5. Endorsements.
6. Amendments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered

Medical Expense. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.

TELEHEALTH/TELEMEDICINE means live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work. Telehealth/Telemedicine also includes the use of information technology, such as synchronous encounters, asynchronous encounters, store and forward transfers, and telemonitoring.

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Named Insured unable to actively attend class. 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. Acne.
2. Addiction, such as:
 - Caffeine addiction.
 - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
 - Codependency.

This exclusion does not apply to benefits specifically provided in the Benefits for Treatment of Mental Illness and Substance Use Disorder.
3. Biofeedback.
4. Chronic pain disorders.
5. Circumcision.
6. Cosmetic procedures, except as specifically provided in the Policy or reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Correct port wine stains.
7. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
8. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - As described under Dental Treatment in the Policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
9. Elective Surgery or Elective Treatment.
10. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline, or chartered aircraft only while participating in a school sponsored activity.
11. Foot care for the following, except as specifically provided in the Policy:
 - Arch supports.
 - Shoe inserts.
 - Supportive devices for the foot.
 - Orthopedic shoes, unless attached to a brace.
 - Support hose.
 - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
12. Health spa or similar facilities. Strengthening programs.
13. Hearing examinations. Hearing aids, except as specifically provided under the Benefits for Hearing Aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

 - Hearing defects or hearing loss as a result of an infection or Injury.
14. Hirsutism. Alopecia.
15. Hypnosis.

16. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
17. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
18. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
19. Injury sustained while:
 - Participating in any intercollegiate or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
20. Investigational services.
21. Lipectomy.
22. Marital or family counseling.
23. Participation in a riot or civil disorder. Commission of or attempt to commit a felony. Fighting.
24. Prescription Drugs, services or supplies as follows, except as specifically provided in the Policy:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes Treatment.
 - Immunization agents, except as specifically provided in the Policy.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the Benefits for Off-Label Drug Use.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
 - Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
25. Reproductive services for the following, except as specifically provided in the Policy:
 - Procreative counseling.
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Female sterilization procedures, except as specifically provided in the Policy.
 - Vasectomy.
 - Reversal of sterilization procedures.
26. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
27. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
This exclusion does not apply as follows:
 - When due to a covered Injury or disease process.
 - To benefits specifically provided in Pediatric Vision Services.
 - To one pair of eyeglasses or contact lenses to treat accommodative strabismus, cataracts, or aphakia.
28. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
29. Preventive care services which are not specifically provided in the Policy, including:
 - Routine physical examinations and routine testing.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
30. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
31. Services provided to an Insured with autism spectrum disorders under an individualized education plan or an individualized family service plan.

32. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except reconstructive surgery for mandibular/maxillary orthognathia. Temporomandibular joint dysfunction. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis. This exclusion does not apply to benefits specifically provided in the Policy.
33. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
34. Sleep disorders.
35. Speech therapy, except as specifically provided in the Policy. Naturopathic services.
36. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
37. Supplies, except as specifically provided in the Policy.
38. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except:
 - As specifically provided in the Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery.
 - Medically Necessary surgery for gynecomastia.
39. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any:
 - Motorcycle.
 - Recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle, four-wheeled all terrain vehicle (ATV), jet ski, ski cycle, or snowmobile.
40. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
41. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
42. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except morbid obesity for an Insured diagnosed as morbidly obese). Surgery to treat morbid obesity is limited to an intestinal bypass, gastric bypass, or gastroplasty. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the Policy.

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 for treatment, or when not in school, to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/MyAccount or submit claims by mail. If submitting by mail, send to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured's insurance Company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied. This time limit does not apply if the Insured is legally incapacitated.

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

HPHC Insurance Company
 c/o UnitedHealthcare StudentResources
 P.O. Box 809025
 Dallas, TX 75380-9025

Section 13: General Provisions

GRACE PERIOD: A grace period of 14 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.

CLAIM FORMS: Claim forms are not required.

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

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

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

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

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

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

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

SUBROGATION: The Company may have a right 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 only on a just and equitable basis and not on the basis of a priority lien. The Company may not exercise this right of recovery without the prior written consent of the Insured. Allowances will be made for legal fees, court costs and compromise settlements.

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 Appeal Rights

RIGHT TO INTERNAL APPEAL **Standard Internal Appeal**

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

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 866-948-8472 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: HPHC Insurance Company c/o UnitedHealthcare StudentResources, PO Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process

Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination.

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

Within 3 working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:

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

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

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

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

The Company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative no later than 30 days after the Company's receipt of the grievance.

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

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

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

7. Notice of the Insured Person's right to contact Bureau of Insurance or Maine's Consumers for Affordable Health Care for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

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

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

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

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, HPHC Insurance Company c/o UnitedHealthcare StudentResources, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Review Process

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

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

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

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

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

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

The notice of Final Adverse Determination may be provided orally, in writing, or electronically. If notification is provided orally or electronically, the Company will also provide written confirmation of the Final Adverse Determination within 2 working days after such initial oral or electronic notification.

Second Level Appeal

When a Final Adverse Determination is upheld through the Internal Appeal Process and the Insured Person is dissatisfied with the first level appeal decision, the Insured Person or Authorized Representative shall be provided an opportunity for a second level appeal. The Insured Person has the right to request an External Independent Review without first exhausting the Company's second level appeal process.

Upon receipt of the request for a Second Level Appeal, the Company shall schedule and hold a review meeting within 45 days after receiving a request from the Insured Person or Authorized Representative to appear in person before the Company. If the Insured Person or Authorized Representative has not requested the opportunity to appear in person before the Company, a decision on the Second Level Appeal will be issued by the Company within 30 calendar days from receipt of the Second Level Appeal request. The Company shall:

1. Hold the review meeting during regular business hours at a location reasonably accessible to the Insured Person or Authorized Representative;
2. Offer the Insured Person or Authorized Representative the opportunity to communicate with the review panel, at the Company's expense, by conference call, video conferencing, or other appropriate technology;
3. Notify the Insured or Authorized Representative, in writing, of the review meeting at least 15 days in advance of the review date. The Company will not unreasonably deny a request, by the Insured Person, for postponement of the review; and
4. Notify the Insured Person or Authorized Representative, within 15 days in advance of the review, when the Company plans to have an attorney present to argue its case against the Insured Person and explain the Insured's right to obtain legal representation.

The Insured Person or Authorized Representative has the right to:

1. Attend the second level review,
2. Present his or her case to the review panel;
3. Submit supporting documentation both before and at the review meeting;
4. Ask questions of any representative of the Company;
5. Be assisted or represented by a person of their choice; and
6. Obtain his or her medical file and information relevant to the appeal free of charge upon request.

The Insured Person's right to a fair review will not be made conditional on the Insured's or Authorized Representative's appearance at the review meeting.

A written decision will be issued to the Insured Person or Authorized Representative within 5 working days after completion of the review meeting. The written decision shall contain the same notice information required for a Final Adverse Determination from the Internal Appeal Process above. If the Insured Person or Authorized Representative has not requested the opportunity to appear in person before the Company, a decision on the Second Level Appeal will be issued by the Company within 30 calendar days from receipt of the Second Level Appeal request.

RIGHT TO EXTERNAL INDEPENDENT REVIEW

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

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 12 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Maine Bureau of Insurance. Upon request of an External Review, the Maine Bureau of Insurance shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the Bureau of Insurance at the following address:

Consumer Health Care Division
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 04333
Phone: 1-800-300-5000 or 1-207-624-8475
TTY: 1-888-577-6690
Fax: 1-207-624-8599
www.maine.gov/insurance
Insurance.PFR@maine.gov

Standard External Review (SER) Process

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

1. After receiving a request for SER, the Bureau of Insurance shall:
 - a. Assign an *Independent Review Organization* (IRO) from the Bureau's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
2.
 - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Bureau of Insurance, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
3. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
4. Within 30 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Bureau of Insurance, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited External Review (EER) Process

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

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Bureau of Insurance at the time the Insured Person receives:
 - a. An Adverse Determination if:
 - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
 - The Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - An Expedited Experimental or Investigational Treatment External Review request if the Adverse Determination involves a denial of coverage based on the determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.
 - b. A Final Adverse Determination, if:
 - The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received Emergency Services, but has not been discharged from a facility; or
 - The Final Adverse Determination involves a denial of coverage based on the determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

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

2. When a request is complete and eligible for an EER, the Bureau of Insurance shall immediately assign an *Independent Review Organization* (IRO) from the Bureau's approved list and notify the Company of the name of the assigned IRO.
 - a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.

- b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
3.
 - a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
4. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
 - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
 - b. Notify the Bureau of Insurance, the Company, the Insured Person, and, if applicable, the Authorized Representative.
5. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

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

APPEAL RIGHTS DEFINITIONS

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

Adverse Determination means:

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

Authorized Representative means:

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

Concurrent Review means Utilization Review conducted during an Insured's Inpatient Hospital stay or course of treatment.

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

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

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

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

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

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

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

Questions Regarding Appeal Rights

Contact Customer Service at 1-866-948-8472 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 department of insurance may be able to assist you at:

Consumers for Affordable Health Care
PO BOX 2490
Augusta, Maine 04338-2490
Consumer Assistance Helpline: 1-800-965-7476 or TTY 1-877-362-9570
Phone: 1-800-838-0388 or 1-207-622-7083
Fax: 1-888-214-5233
www.maineahc.org

Section 15: Online Access to Account Information

HPHC Insurance Company 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 HPHC Insurance Company's 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 16: 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.
- 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 the primary; includes provider, date of service, status, claim amount and amount paid.

Section 17: Important Company Contact Information

The Policy is Underwritten by:
HPHC INSURANCE COMPANY

Administrative Office:
HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-866-948-8472
Website: www.uhcsr.com

Serviced by:
Gallagher Student Health & Special Risk
500 Victory Road
Quincey, MA 02171
1-866-948-8472
www.gallagherstudent.com

Sales/Marketing Services:
HPHC Insurance Company
c/o UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
Email: info@uhcsr.com

Customer Service:
866-948-8472

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

Section 18: Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

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

Non-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental

Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. When the Insured Person obtains Covered Dental Services from non-Network Dental Providers, the Insured Person must file a claim with the Company to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

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

Section 2: Benefits for Pediatric Dental Services

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

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

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

Non-Network Benefits:

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

Dental Services Deductible

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

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

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

Benefits

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

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

Benefit Description

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
Diagnostic Services - (Subject to payment of the Dental Services Deductible.)		
<p><i>Evaluations (Checkup Exams)</i></p> <p>Limited to 2 times per 12 months.</p> <p>Covered as a separate benefit only if no other service was done during the visit other than X-rays.</p> <p>D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review</p> <p>D0150 - Comprehensive oral evaluation D0180 - Comprehensive periodontal evaluation</p> <p>The following service is not subject to a frequency limit.</p> <p>D0160 - Detailed and extensive oral evaluation - problem focused</p>	50%	50%
<p><i>Intraoral Radiographs (X-ray)</i></p> <p>Limited to 2 series of films per 12 months.</p> <p>D0210 - Complete series (including bitewings)</p>	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	Non-Network Benefits
D0709 - Intraoral - complete series of radiographic images - image capture only		
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first film D0230 - Intraoral - periapical - each additional film D0240 - Intraoral - occlusal film D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only	50%	50%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewings - single film D0272 - Bitewings - two films D0274 - Bitewings - four films D0277 - Vertical bitewings D0708 - Intraoral - bitewing radiographic image - image capture only	50%	50%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only D0704 - 3-D Photographic image - image capture only	50%	50%
The following services are limited to 2 images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%	50%
The following services are not subject to a frequency limit. D0340 - Cephalometric X-ray D0350 - Oral/Facial photographic images D0391 - Interpretation of diagnostic images D0470 - Diagnostic casts D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	50%	50%
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings)	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	Non-Network Benefits
<p>The following services are limited to 2 times every 12 months.</p> <p>D1110 - Prophylaxis - adult D1120 - Prophylaxis - child</p>		
<p><i>Fluoride Treatments</i></p> <p>The following services are limited to 2 times every 12 months.</p> <p>D1206 and D1208 - Fluoride</p>	50%	50%
<p><i>Sealants (Protective Coating)</i></p> <p>The following services are limited to once per first or second permanent molar every 36 months.</p> <p>D1351 - Sealant - per tooth - unrestored permanent molar D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth</p>	50%	50%
<p><i>Space Maintainers (Spacers)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant</p>	50%	50%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
<i>Amalgam Restorations (Silver Fillings)</i>	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	Non-Network Benefits
<p>The following services are not subject to a frequency limit.</p> <p>D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent</p>		
<p><i>Composite Resin Restorations (Tooth Colored Fillings)</i></p> <p>The following services are not subject to a frequency limit.</p> <p>D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incised angle, anterior</p>	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
<p>The following services are subject to a limit of 1 time every 60 months.</p> <p>D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four surfaces D2740 - Crown - porcelain/ceramic substrate D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal</p>	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	Non-Network Benefits
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 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 inlay D2920 - Re-cement crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following services are limited to 1 time per tooth every 60 months. D2929 - Prefabricated porcelain crown - primary D2950 - Core buildup, including any pins	50%	50%
The following service is limited to 1 time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to crown	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair D2982 - Onlay repair D2983 - Veneer repair D2990 - Resin infiltration/smooth surface	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration)	50%	50%
The following service is 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	Non-Network Benefits
D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development		
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%	50%
The following services are not subject to a frequency limit. D3310 - Anterior root canal (excluding final restoration) D3320 - Bicuspid root canal (excluding final restoration) D3330 - Molar root canal (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
The following service is not subject to a frequency limit. D3354 - Pulpal regeneration	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy/periradicular - anterior D3421 - Apicoectomy/periradicular - bicuspid D3425 - Apicoectomy/periradicular - molar D3426 - Apicoectomy/periradicular - each additional root D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar	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	Non-Network Benefits
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		
The following service is not subject to a frequency limit. D3450 - Root amputation - per root	50%	50%
The following service is not subject to a frequency limit. D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more teeth D4211 - Gingivectomy or gingivoplasty - one to three teeth D4212 - Gingivectomy or gingivoplasty - with restorative procedures - per tooth	50%	50%
The following services are limited to 1 every 36 months. D4240 - Gingival flap procedure, four or more teeth D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following service is not subject to a frequency limit. D4249 - Clinical crown lengthening - hard tissue	50%	50%
The following services are limited to 1 every 36 months. D4260 - Osseous surgery D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft - first site in quadrant	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	Non-Network Benefits
D4270 - Pedicle soft tissue graft procedure D4271 - Free soft tissue graft procedure		
The following services are not subject to a frequency limit. D4273 - Subepithelial connective tissue graft procedures, per tooth D4275 - Soft tissue allograft D4277 - Free soft tissue graft - first tooth D4278 - Free soft tissue graft - additional teeth	50%	50%
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%	50%
The following service is limited to a frequency to 1 per lifetime. D4355 - Full mouth debridement to enable comprehensive evaluation and diagnosis	50%	50%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	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	Non-Network Benefits
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) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests and teeth) - per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5510 - Repair broken complete denture base	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	Non-Network Benefits
D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture D5610 - Repair resin denture base D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5620 - Repair cast framework D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture		
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)	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	Non-Network Benefits
D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)		
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. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are not subject to a frequency limit. D6519 - Inlay/onlay - porcelain/ceramic D6520 - Inlay - metallic - two surfaces D6530 - Inlay - metallic - three or more surfaces D6543 - Onlay - metallic - three surfaces D6544 - Onlay - metallic - four or more surfaces	50%	50%
The following services are limited to 1 time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal	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	Non-Network Benefits
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		
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond fixed partial denture	50%	50%
The following services are not subject to a frequency limit. D6973 - Core build up for retainer, including any pins D6980 - Fixed partial denture repair necessitated by restorative material failure	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root	50%	50%
The following services are not subject to a frequency limit. D7210 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal	50%	50%
The following service is 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	Non-Network Benefits
D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth		
The following service is not subject to a frequency limit. D7280 - Surgical access of an unerupted tooth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth space - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%	50%
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess D7910 - Suture of recent small wounds up to 5 cm D7921 - Collect - apply autologous product D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva	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. D9110 - Palliative (Emergency) treatment of dental pain - minor 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	Non-Network Benefits
<p>Covered only when clinically Necessary.</p> <p>D9220 - Deep sedation/general anesthesia first 30 minutes D9221 - Dental sedation/general anesthesia each additional 15 minutes D9222 - Deep sedation/general anesthesia - first 15 minutes D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9241 - Intravenous conscious sedation/analgesia - first 30 minutes D9242 - Intravenous conscious sedation/analgesia - each additional 15 minutes D9610 - Therapeutic drug injection, by report</p>	50%	50%
<p>Covered only when clinically Necessary</p> <p>D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)</p>	50%	50%
<p>The following is limited to 1 guard every 12 months.</p> <p>D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch</p>	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
<p>The following services are limited to 1 time every 60 months.</p> <p>D6010 - Endosteal implant D6012 - Surgical placement of interim implant body D6040 - Eposteal implant D6050 - Transosteal implant, including hardware D6053 - Implant supported complete denture D6054 - Implant supported partial denture D6055 - Connecting bar implant or abutment supported D6056 - Prefabricated abutment D6057 - Custom abutment D6058 - Abutment supported porcelain ceramic crown</p>	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	Non-Network Benefits
<p>D6059 - Abutment supported porcelain fused to high noble metal</p> <p>D6060 - Abutment supported porcelain fused to predominately base metal crown</p> <p>D6061 - Abutment supported porcelain fused to noble metal crown</p> <p>D6062 - Abutment supported cast high noble metal crown</p> <p>D6063 - Abutment supported cast predominately base metal crown</p> <p>D6064 - Abutment supported porcelain/ceramic crown</p> <p>D6065 - Implant supported porcelain/ceramic crown</p> <p>D6066 - Implant supported crown - porcelain fused to high noble alloys</p> <p>D6067 - Implant supported crown - high noble alloys</p> <p>D6068 - Abutment supported retainer for porcelain/ceramic fixed partial denture</p> <p>D6069 - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture</p> <p>D6070 - Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture</p> <p>D6071 - Abutment supported retainer for porcelain fused to noble metal fixed partial denture</p> <p>D6072 - Abutment supported retainer for cast high noble metal fixed partial denture</p> <p>D6073 - Abutment supported retainer for predominately base metal fixed partial denture</p> <p>D6074 - Abutment supported retainer for cast metal fixed partial denture</p> <p>D6075 - Implant supported retainer for ceramic fixed partial denture</p> <p>D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys</p> <p>D6077 - Implant supported retainer for metal FPD - high noble alloys</p> <p>D6078 - Implant/abutment supported fixed partial denture for completely edentulous arch</p> <p>D6079 - Implant/abutment supported fixed partial denture for partially edentulous arch</p> <p>D6080 - Implant maintenance procedure</p> <p>D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including</p>		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.

What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
<p>cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant prosthesis D6091 - Replacement of replaceable part of semi-precision or precision attachment D6095 - Repair implant abutment D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Implant removal D6101 - Debridement peri-implant defect D6102 - Debridement and osseous peri-implant defect D6103 - Bone graft peri-implant defect D6104 - Bone graft implant replacement D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 - Implant index</p>		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	Network Benefits	Non-Network Benefits
D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
<p>Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.</p>		
<p>The following services are not subject to a frequency limitation as long as benefits have been prior authorized.</p> <p>D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8050 - Interceptive orthodontic treatment of the primary dentition D8060 - Interceptive orthodontic treatment of the transitional dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary</p>	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	Non-Network Benefits
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		

Section 3: Pediatric Dental Exclusions

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

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

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

HPHC Insurance Company
c/o UnitedHealthcare Dental
ATTN: Claims Unit
P. O. Box 30567
Salt Lake City, UT 84130-0567

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

Section 5: Defined Terms for Pediatric Dental Services

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

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).

- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

Section 19: Pediatric Vision Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Non-Network Benefits:

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

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

Policy Deductible

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

What Are the Benefit Descriptions?

Benefits

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

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

Frequency of Service Limits

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

Routine Vision Examination

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

- A patient history that includes reasons for exam, patient medical/eye history, and current medications.
- Visual acuity with each eye and both eyes, far and near, with and without glasses or contact lenses (for example, 20/20 and 20/40).

- Cover test at 20 feet and 16 inches (checks how the eyes work together as a team).
- Ocular motility (how the eyes move) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception (3D vision).
- Pupil reaction to light and focusing.
- Exam of the eye lids, lashes, and outside of the eye.
- Retinoscopy (when needed) – helps to determine the starting point of the refraction which determines the lens power of the glasses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation – how well the Insured Person sees up close (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the inside of the eye.
- Visual field testing.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

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

Eyeglass Lenses

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

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

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

Eyeglass Frames

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

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

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

Contact Lenses

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

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

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

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company.

Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.

- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of \$20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of \$40.	50% of the billed charge.
• Bifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Lenticular		100% after a Copayment of \$40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - 160.		100% after a Copayment of \$15.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - 200.		100% after a Copayment of \$30.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - 250.		100% after a Copayment of \$50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of \$40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of \$40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services*.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

UnitedHealthcare Vision Network - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the Policy.

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

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

Section 20: UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

Benefits 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 benefit provision.

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.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after $\frac{3}{4}$ of the original Prescription Drug Product has been used. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.

The Insured must present their ID card to the Network Pharmacy when the prescription is filled. If the Insured does not present their ID card to the Network Pharmacy, they will need to pay for the Prescription Drug and 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.

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.

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 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.

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy or a Preferred 90 Day Retail 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 been assigned a maximum quantity level for dispensing at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

Prescription Drug Coverage During A State of Emergency

Coverage will be provided for the furnishing or dispensing of a Prescription Drug Product in accordance with a valid prescription issued by a Provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply, during a statewide state of emergency declared by the Governor in accordance with *Title 37-B, section 742*. This does not apply to coverage of prescribed contraceptive supplies or opioids.

If a Brand-name Drug Becomes Available as a Generic

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

Designated Pharmacies

If the Insured requires certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their 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 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 Prescription Drug Product.

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, no benefits will be paid for that 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) 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) 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.

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) based on the applicable tier.

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 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.

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.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to obtain prior authorization from the Company or the Company's designee. The reason for obtaining prior authorization from 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 or Investigational or Unproven Service.

Prior authorization will not be required for at least one Prescription Drug Product for treatment for opioid use disorder in each therapeutic class of medication used in medication-assisted treatment. Prior authorization will not be required for medication-assisted treatment for opioid use disorder for Insureds who are pregnant.

Prior authorization will be approved for a Prescription Drug Product on the Prescription Drug List that is prescribed to assess or treat a serious mental illness. A "serious mental illness" means a mental disorder, as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* that results in serious functional impairment that substantially interferes with or limits one or more major life activities.

If the Insured does not obtain prior authorization from the Company before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring prior authorization 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 prior authorization at www.uhcsr.com or by calling *Customer Service* at 1-855-828-7716.

If the Insured does not obtain prior authorization from the Company 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 obtain prior authorization from the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any Deductible that applies.

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

The Company will accept and respond to prior authorization requests through a secure electronic transmission using standards adopted by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. Transmission of a facsimile through a proprietary payer portal or by used of an electronic form is not considered electronic transmission.

Step Therapy

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.

Clinical review criteria used to establish a step therapy protocol will be based on clinical practice guidelines that:

- Recommend that the Prescription Drug Products be taken in the specific sequence required by the step therapy protocol.
- Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among the members of the writing and review groups by:

- Requiring Insured Persons to disclose any potential conflicts of interest with entities, including carriers and pharmaceutical manufacturers, and recuse themselves from voting if they have a conflict of interest.
- Using a methodologist to work with writing groups to provide objectivity in data analysis and ranking of evidence through the preparation of evidence tables and facilitating consensus.
- Offering opportunities for public review and comments.
- Are based on high-quality studies, research and medical practice.
- Are created by an explicit and transparent process that:
 - Minimizes biases and conflicts of interest.
 - Explains the relationship between treatment options and outcomes.
 - Rates the quality of the evidence supporting recommendations.
 - Considers relevant patient subgroups and preferences.
 - Are continually updated through a review of new evidence, research and newly developed treatments.

In the absence of clinical practice guidelines that meet the above requirements, peer-reviewed publications may be substituted.

Prescription Drug Products on the Prescription Drug List that are prescribed to assess or treat a serious mental illness will be approved. Prescription Drugs on the Prescription Drug List that are prescribed for a serious mental illness will not require step therapy.

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.

Limitation on Selection of Pharmacies

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's 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. 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.

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 prior authorization 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.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others, therefore; a Prescription Drug may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

The Company may, from time to time, change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may happen without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

NOTE: The tier 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 benefit provision. 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.

Continuity of Prescriptions

If the Insured Person has been receiving a Prescription Drug based on a prior authorization from another insurer, and the Insured's coverage with that insurer has been replaced with coverage under this Policy, the Company will honor the Insured Person's prior insurer's prior authorization of the Prescription Drug, for a period not to exceed 6 months, until the Company has the opportunity to conduct a review with the Insured Person's prescribing provider. The Company is not required to provide benefits under this section for conditions or services not otherwise covered under this Policy and the Insured Person's cost sharing responsibility will be based on any applicable Copayment, Coinsurance or Deductible requirements of this Policy.

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources. 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 or Investigational Services means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications, or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

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

Exceptions:

- Clinical trials for which benefits are specifically provided for in the Policy.
- If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the Policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

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.

Preferred 90 Day Retail Network Pharmacy means a retail pharmacy that the Company identifies as a preferred pharmacy within the network for Maintenance Medication.

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

Prescription Drug or 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 appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the Policy, this definition includes:

- Inhalers.
- Insulin.
- Certain vaccines/immunizations administered in 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 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 Management Committee means the committee that the Company designates for placing Prescription Drugs into specific tiers.

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.

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.

Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. 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.

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

Unproven Service(s) means services, including medications, that are determined not to be effective for the treatment of the medical condition and/or not to have a beneficial effect on the health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

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

The Company has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Company issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, as it determines, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

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. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven. This exclusion does not apply to drugs that have not been approved by the Federal Food and Drug Administration for that indication, if the drug has been prescribed for the Insured Person, provided the drug is recognized in one of the standard reference compendia or in peer-reviewed medical literature.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.

6. 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.)
7. 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.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.
9. 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.
10. 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.
11. 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.
12. A Prescription Drug Product with an approved biosimilar or 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 showing that it is highly similar to a reference product (a biological Prescription Drug Product) and 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, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Durable medical equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy.
15. Diagnostic kits and products.
16. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
17. 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.

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 1-866-948-8472. The Company will notify the Insured Person of the Company’s determination within 72 hours or two business days of receipt of the request, whichever is less.

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 1-866-948-8472. The *Independent Review Organization (IRO)* will notify the Insured Person of the determination within 72 hours or two business days of receipt of the request, whichever is less.

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 1-866-948-8472 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.

Schedule of Benefits

University of Maine System

2022-200202-1

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 84.860%

Injury and Sickness Benefits

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

Deductible Preferred Provider	\$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	\$400 (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	\$7,900 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	\$15,800 (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 HPHC Insurance Company Network.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. "Network area" means 1) for primary care services, providers available within 30 minutes travel time and 2) for specialty care and hospital services, providers available within 60 minutes travel time by automobile of the local school campus the Named Insured is attending.

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.

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred after a \$10 Copay per visit when treatment is rendered at or referred by the Student Health Center.

Out-of-Country Claims: Covered Medical Expenses incurred outside the United States will be paid at the Out-of-Network Provider Benefit level.

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	80% of Allowed Amount after Deductible

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	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 Payable within 7 working days prior to admission.	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.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
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	\$30 Copay per visit not subject to Deductible	Allowed Amount after Deductible
Physiotherapy Limits per Policy Year as follows: 40 visits of speech therapy 40 visits of any combination of physical therapy and occupational therapy Separate physical, occupational, and speech therapy limits apply to rehabilitative and Habilitative Services. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Cardiac Rehabilitation	Allowed Amount after Deductible	Allowed Amount after Deductible
Medical Emergency Expenses	\$200 Copay per visit Allowed Amount after Deductible	\$200 Copay per visit 80% 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

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
<p>Prescription Drugs *See UHCP Prescription Drug Benefit for additional information.</p> <p>For insulin drugs, the total amount of Deductible, Copayments or Coinsurance shall not exceed \$35 for an individual prescription of up to a 30-day supply.</p>	<p>*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy \$15 Copay per prescription Tier 1 \$45 Copay per prescription Tier 2 \$75 Copay per prescription Tier 3 up to a 31 day supply per prescription not subject to Deductible</p> <p>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).</p> <p>UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply</p>	<p>40% of billed charges generic drug 40% of billed charges brand-name drug up to a 31-day supply per prescription after Deductible</p>

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	80% of Allowed Amount after Deductible
Durable Medical Equipment See also Benefits for Prosthetic Devices	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees	\$30 Copay per visit not subject to Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth and removal of impacted or unerupted teeth only.	Allowed Amount after Deductible	Allowed Amount after Deductible
Mental Illness Treatment See Benefits for Mental Illness and Substance Use Disorder	<p>Inpatient: Allowed Amount after Deductible</p> <p>Outpatient office visits: \$30 Copay per visit not subject to Deductible</p> <p>All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: Allowed Amount after Deductible</p>	<p>Inpatient: Allowed Amount after Deductible</p> <p>Outpatient office visits: Allowed Amount after Deductible</p> <p>All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: Allowed Amount after Deductible</p>
Substance Use Disorder Treatment See Benefits for Mental Illness and Substance Use Disorder	<p>Inpatient: Allowed Amount after Deductible</p> <p>Outpatient office visits: \$30 Copay per visit not subject to Deductible</p> <p>All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: Allowed Amount after Deductible</p>	<p>Inpatient: Allowed Amount after Deductible</p> <p>Outpatient office visits: Allowed Amount after Deductible</p> <p>All other outpatient services, except Medical Emergency Expenses and Prescription Drugs: Allowed Amount after Deductible</p>
Maternity	Paid as any other Sickness	Paid as any other Sickness

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	Allowed Amount after Deductible	Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. 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	80% of Allowed Amount not subject to Deductible
Reconstructive Breast Surgery Following Mastectomy See Benefits for Breast Cancer Treatment and Reconstructive Breast Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes Treatment	Paid as any other Sickness	Paid as any other Sickness
Home Health Care See Benefits for Home Health Care	Paid as any other Sickness	Paid as any other Sickness
Hospice Care See Benefits for Hospice Care Services	Paid as any other Sickness	Paid as any other Sickness
Inpatient Rehabilitation Facility 150 days maximum (per Policy Year) total combined benefit with Skilled Nursing Facility benefits	Allowed Amount after Deductible	Allowed Amount after Deductible
Skilled Nursing Facility 150 days maximum (per Policy Year) total combined benefit with Inpatient Rehabilitation Facility benefits	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	\$30 Copay per visit not subject to Deductible	Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Approved Clinical Trials See also Benefits for 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
Educational Services	Paid as any other Sickness	Paid as any other Sickness
Massage Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Medical Supplies Benefits are limited to a 31-day supply per purchase	Allowed Amount after Deductible	Allowed Amount after Deductible
Smoking Cessation	Paid as any other Sickness	Paid as any other Sickness

HPHC 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.

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:

Domestic Students 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 the need for and the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician Advisors and treating physicians as needed to make its determination.

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

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

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

1. Travel costs that were neither arranged nor approved in advance by the Company's affiliate or authorized vendor.
2. Taking part in military or police service operations.
3. Insured Person's failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
4. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.
5. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
7. Medical Evacuations directly or indirectly related to a natural disaster.
8. Subsequent Medical Evacuations for the same or related Sickness, Injury or Emergency Medical Event regardless of location.

Additional Assistance Services

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

MEDICAL ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

WORLDWIDE DESTINATION INTELLIGENCE

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

TRAVEL ASSISTANCE SERVICES

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

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

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

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

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

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

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

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

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

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

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

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

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

NON-DISCRIMINATION NOTICE

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

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

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

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

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

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

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

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

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

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

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

