2016–2017 Student Injury and Sickness Insurance Plan

DESIGNED ESPECIALLY FOR THE INTERNATIONAL STUDENTS OF

The Plan is underwritten by
UNITEDHEALTHCARE INSURANCE COMPANY
# Table of Contents

Privacy Policy ........................................................................................................................................ 1
Eligibility ................................................................................................................................................ 1
Effective and Termination Dates ............................................................................................................. 1
Student Health Clinic Information ............................................................................................................. 1
Extension of Benefits after Termination .................................................................................................... 1
Preferred Provider Information ................................................................................................................ 1
Schedule of Medical Expense Benefits ..................................................................................................... 2
Medical Expense Benefits – Injury and Sickness ....................................................................................... 5
Mandated Benefits .................................................................................................................................... 11
Coordination of Benefits Provision .......................................................................................................... 11
Definitions ............................................................................................................................................... 12
Exclusions and Limitations ....................................................................................................................... 15
UnitedHealthcare Global: Global Emergency Services ............................................................................... 17
Claim Procedures for Injury and Sickness Benefits .................................................................................... 18
Pediatric Dental Services Benefits ........................................................................................................... 19
Pediatric Vision Care Services Benefits .................................................................................................... 25
Notice of Appeal Rights ............................................................................................................................. 29
Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-953-1801 or visiting us at www.uhcsr.com.

Eligibility

All International students registered for classes are eligible and automatically enrolled in this insurance plan at registration, unless proof of comparable coverage is provided.

Accident coverage for Intercollegiate Sports injuries is provided under a separate policy number 2016-353-84.

Students must actively attend classes for at least the first 30 days after the date for which coverage is purchased. Home study, correspondence and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2016. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 20, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

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

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

Student Health Clinic Information

For information regarding benefits at the Student Health Clinic please refer to the 2016-2017 SHIP Benefits at the Student Health Clinic brochure available at www.uidaho.edu/ship.

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 90 days after the Termination Date.

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

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

Preferred Provider Information

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

First Choice in the states of Idaho, Washington, and Montana and PHCS outside of those states.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-636-7427 and/or by asking the provider when making an appointment for services.
“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

“Out-of-Network” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured’s responsibility.

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call 1-888-636-7427 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by First Choice and PHCS will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Schedule of Medical Expense Benefits

METALLIC LEVEL: SILVER WITH ACTUARIAL VALUE OF 73.866%

<table>
<thead>
<tr>
<th>Injury and Sickness Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)</td>
</tr>
<tr>
<td>Deductible Preferred Providers</td>
</tr>
<tr>
<td>Deductible Out-of-Network</td>
</tr>
<tr>
<td>Coinsurance Preferred Providers</td>
</tr>
<tr>
<td>Coinsurance Out-of-Network</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Providers</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Out-of-Network</td>
</tr>
</tbody>
</table>

The Preferred Providers for this plan are First Choice in the states of Idaho, Washington and Montana and PHCS outside of those states.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. Covered Medical Expense incurred at a Preferred Provider facility by an Out-of-Network Provider will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Any applicable 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.

Copays and Per Service Deductibles: All Copays and per service Deductibles specified in the Schedule of Benefits are in addition to the policy Deductible, except as specifically noted.
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 unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Room and Board Expense</strong></td>
<td>Preferred Allowance $150 Copay per Hospital Confinement</td>
<td>Usual and Customary Charges $150 Deductible per Hospital Confinement</td>
</tr>
<tr>
<td><strong>Intensive Care</strong></td>
<td>Preferred Allowance $150 Copay per Hospital Confinement</td>
<td>Usual and Customary Charges $150 Deductible per Hospital Confinement</td>
</tr>
<tr>
<td><strong>Hospital Miscellaneous Expenses</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Routine Newborn Care</strong></td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>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.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Assistant Surgeon Fees</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Anesthetist Services</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Registered Nurse's Services</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Physician's Visits</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Pre-admission Testing</strong></td>
<td>Payable within 7 working days prior to admission.</td>
<td>Preferred Allowance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>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.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Day Surgery Miscellaneous</strong></td>
<td>Preferred Allowance $150 Copay per date of service</td>
<td>Usual and Customary Charges $150 Deductible per date of service</td>
</tr>
<tr>
<td>Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.</td>
<td>Preferred Allowance $150 Copay per date of service</td>
<td>Usual and Customary Charges $150 Deductible per date of service</td>
</tr>
<tr>
<td><strong>Assistant Surgeon Fees</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Anesthetist Services</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Physician's Visits</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Includes coverage for travel immunizations.</td>
<td>Preferred Allowance $150 Copay per visit</td>
<td>Usual and Customary Charges $150 Deductible per visit</td>
</tr>
<tr>
<td><strong>Physiotherapy</strong></td>
<td>Preferred Allowance $150 Copay per visit</td>
<td>Usual and Customary Charges $150 Deductible per visit</td>
</tr>
<tr>
<td>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Benefits are payable for Acupuncture under this benefit.</td>
<td>Preferred Allowance $150 Copay per visit</td>
<td>Usual and Customary Charges $150 Deductible per visit</td>
</tr>
<tr>
<td><strong>Medical Emergency Expenses</strong></td>
<td>Preferred Allowance $150 Copay per visit</td>
<td>Usual and Customary Charges $150 Deductible per visit</td>
</tr>
<tr>
<td>Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Deductible will be waived if admitted to the Hospital. The Copay/per visit Deductible is in lieu of Policy Deductible.</td>
<td>Preferred Allowance $150 Copay per visit</td>
<td>Usual and Customary Charges $150 Deductible per visit</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Preferred Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Diagnostic X-ray Services</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Tests &amp; Procedures</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Injections</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral vaccines for typhoid are covered.</td>
<td>Magellan Rx Management</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td></td>
<td>$30 Copay per prescription for generic drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$60 Copay per prescription for formulary drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100 Copay per prescription for non-formulary drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>up to a 30 day supply per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Mail order is available through Magellan RX Management for up to a 90 day supply at 3 times the 31 day supply retail Copay.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If a retail Magellan RX Management pharmacy agrees to the same rates, terms and requirements associated with dispensing a 90 day supply, then up to a consecutive 90 day supply of a Prescription Drug at 3 times the copay that applies to a 31 day supply per prescription.</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Preferred Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>Preferred Allowance</td>
<td>75% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Benefits include prosthetic devices.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Physician Fees</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Dental Treatment</td>
<td>Preferred Allowance</td>
<td>75% of Usual and Customary Charges</td>
</tr>
<tr>
<td>Benefits paid on Injury to Sound, Natural Teeth only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness Treatment</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Maternity</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Complications of Pregnancy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>100% of Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit <a href="https://www.healthcare.gov/preventive-care-benefits/">https://www.healthcare.gov/preventive-care-benefits/</a> for a complete list of services provided for specific age and risk groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reconstructive Breast Surgery Following Mastectomy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>See Benefits for Reconstructive Breast Surgery Following Mastectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>High Cost Procedures</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td></td>
<td>$200 Copay per procedure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$200 Deductible per procedure</td>
<td></td>
</tr>
</tbody>
</table>
### Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available in the Schedule of Benefits.

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

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

#### Inpatient

1. **Room and Board Expense.**
   Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

2. **Intensive Care.**
   If provided in the 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.

<table>
<thead>
<tr>
<th>Other</th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Outpatient Facility or Clinic</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Approved Clinical Trials</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Testing, treatment and Durable Medical Equipment are covered.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
</tbody>
</table>
5. **Surgery (Inpatient).**
   Physician's fees for Inpatient surgery.

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

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

8. **Registered Nurse's Services.**
   Registered Nurse's services which are all of the following:
   - Private duty nursing care only.
   - Received when confined as an Inpatient.
   - Ordered by a licensed Physician.
   - 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 (Inpatient).**
   Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.

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 (Outpatient).**
   Physician’s fees for outpatient surgery. When these services are performed in a Physician’s office, benefits are payable under Physician’s Visits (Outpatient).

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

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

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

15. **Physician's Visits (Outpatient).**
   Services provided in a Physician’s office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to Physiotherapy.

   Benefits include the following services when performed in the Physician's office:
   - Surgery.
   - X-rays.
   - Laboratory procedures.
   - Tests and procedures.
Physician’s Visits for preventive care are provided as specified under Preventive Care Services.

16. **Physiotherapy** *(Outpatient)*. Includes but is not limited to the following rehabilitative services (including Habilitative Services):
   - Physical therapy.
   - Occupational therapy.
   - Cardiac rehabilitation therapy.
   - Manipulative treatment.
   - Speech therapy.

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

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

18. **Diagnostic X-ray Services** *(Outpatient)*. Diagnostic X-rays are only those procedures identified in *Physicians’ Current Procedural Terminology* (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.


20. **Laboratory Procedures** *(Outpatient)*. Laboratory Procedures are only those procedures identified in *Physicians’ Current Procedural Terminology* (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

21. **Tests and Procedures** *(Outpatient)*. Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:
   - Physician’s Visits.
   - Physiotherapy.
   - X-rays.
   - Laboratory Procedures.

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

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

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

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

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

**Other**

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

27. **Consultant Physician Fees.**

Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**

Dental treatment when services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.

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

Benefits will also be provided for Hospital or facility charges and general anesthesia services in connection with dental procedures if certified by a Physician that a non-dental medical condition requires Hospital Confinement to safeguard the health of the Insured Person. The following non-dental medical conditions may receive these Hospital benefits:
- Brittle diabetes.
- History of a life-endangering heart condition.
- History of uncontrollable bleeding.
- Severe bronchial asthma.
- Children under 10 years of age who require general anesthetic.
- Other non-dental life-endangering conditions that require hospitalization.

This does not include expenses for the dental procedure.

29. **Mental Illness Treatment.**

Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

30. **Substance Use Disorder Treatment.**

Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- On an outpatient basis including intensive outpatient treatment.

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.

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

Benefits defined under the Health Resources and Service Administration include the following services:
- BRCA risk assessment testing, genetic testing, and genetic counseling.
- Benefits defined under the Health Resources and Services Administration, including:
- At least one form of contraception without cost sharing in each of the methods (currently 18) the FDA has identified for women in its current Birth Control Guide, including clinical services, such as patient education and counseling, needed for provision of the contraceptive method. Contraceptive methods include, but are not limited to, hormonal methods such as oral contraceptives, barrier methods such as prescription diaphragms and implanted devices, and oral medications for emergency contraception. If the Insured’s Physician recommends a specific service or FDA-approved item based on Medical Necessity with respect to that Insured, the policy must cover that service without cost sharing.
- Screening and counseling for interpersonal and domestic violence.
- Breastfeeding support and counseling.
- The cost of renting one breast pump per pregnancy in conjunction with childbirth.

Benefits include medically appropriate gender-specific recommended Preventive Care Services as determined by the Insured’s Physician, regardless of the Insured’s gender assigned at birth, gender identity, or gender of the Insured as otherwise recorded by the Company.

Information about recommended Preventive Care Services may be obtained online at:

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and
http://www.hrsa.gov/womensguidelines/

34. Reconstructive Breast Surgery Following Mastectomy.
Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Reconstructive Surgery Following Mastectomy.

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

Benefits will be paid for Medically Necessary:
- Outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.
- Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.

36. High Cost Procedures.
The following procedures provided on an outpatient basis:
- CT Scan.
- PET Scan.
- Magnetic Resonance Imaging.
37. **Home Health Care.**
Services received from a licensed home health agency that are:

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

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

38. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.

Hospice care includes:

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

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

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

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

41. **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.

42. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

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

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

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

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

“Life-threatening condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
“Approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

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

44. Transplantation Services.

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 this policy.

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, lodging expenses, and food costs may be reimbursed based on the Company’s guidelines that are available upon request from customer service. 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.

Mandated Benefits

Benefits for Mammography

If benefits are provided for the surgical procedure known as a mastectomy, benefits will also be provided as for any other Sickness for a mammography subject to all terms and conditions of the policy and according to the following guidelines:

1. One baseline mammogram for any woman who is thirty-five through thirty-nine years of age.
2. A mammogram every 2 years for any woman who is forty through forty-nine years of age, or more frequently if recommended by the woman’s physician.
3. A mammogram every year for any woman who is fifty years of age or older.
4. A mammogram for any woman desiring a mammogram for Medical Necessity.

“Mastectomy” means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

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

Benefits for Reconstructive Breast Surgery Following Mastectomy

Benefits will be paid the same as any other Sickness for reconstructive surgery following a covered mastectomy when the Insured Person elects breast reconstruction in connection with the mastectomy. The coverage shall include the following:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications for all stages of mastectomy including lymphedemas.

Benefits will be provided upon recommendation of a Physician as determined by consultation between the Physician and the patient.

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

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

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

COMPLICATION OF PREGNANCY means a condition: 1) which requires the Insured to be Hospital Confined (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia and toxemia.

CONGENITAL CONDITION means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. For the purposes of this definition, significant deviation is a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital condition.

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

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

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

CUSTODIAL CARE means services that are any of the following:

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

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

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:

1. A medical screening examination that is within the capability of the emergency department of a Hospital; including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.
HABILITATIVE SERVICES means outpatient occupational therapy, physical therapy and speech therapy prescribed by the Insured Person’s treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

Habilitative services do not include 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. When the Insured Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

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 or in facilities available to the Hospital on a pre-arranged basis and under the supervision of a duly licensed Physician; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

INJURY means bodily injury which is all of the following:

1. directly and independently caused by specific accidental contact with another body or object.
2. unrelated to any pathological, functional, or structural disorder.
3. a source of loss.
4. treated by a Physician within 30 days after the date of accident.
5. sustained while the Insured Person is covered under this policy.

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

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under this 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 the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

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

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

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

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

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

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

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

**NEWBORN INFANT AND ADOPTED CHILD** means any newborn child of an Insured and any newborn adopted child placed with the Insured within 60 days after birth while that person is insured under this policy. Any such child will be covered under the policy for the first 60 days after birth. In the case of an adopted child placed with the Insured more than 60 days after the birth of the child while that person is insured under this policy, coverage shall begin on the date the child is so placed. Coverage for such newborn or adopted child will be for Injury or Sickness, including medically diagnosed Congenital Conditions, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child’s parent.

Prior to legal finalization of adoption, coverage shall be provided for a child placed for adoption in the same manner as it would with respect to a naturally born child of the Insured until the first to occur of the following events:

a) The date the child is removed permanently from that placement and the legal obligation terminates; or
b) The date the Insured rescinds, in writing, the agreement of adoption or agreement assuming financial responsibility.

The term “placed” shall mean physical placement in the care of the Insured, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the Insured signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child.

**OUT-OF-POCKET MAXIMUM** means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.
**PHYSICIAN** means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. The term “member of the immediate family” means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

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

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

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

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

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

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

**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.

**TOTALLY DISABLED** means a condition of a Named Insured which, because of Sickness or Injury, renders the Insured unable to actively attend classes.

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

**USUAL AND CUSTOMARY CHARGES** means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

**Exclusions and Limitations**

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

1. Addiction, such as:
   - Caffeine addiction.
   - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
   - Codependency.
4. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Treat or correct a Congenital Condition of a covered Dependent child.
• Treat or correct Congenital Conditions of a Newborn Infant and Adopted Child.

5. 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.

6. 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.

7. Elective Surgery or Elective Treatment.

8. Elective abortion, except to preserve the life of the female upon whom the abortion is performed.

9. Health spa or similar facilities. Strengthening programs.

10. Hearing examinations. 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.

11. Hirsutism.


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

14. Injuries occurring during practice or play of curricular or competitive sports activities as a member of the school sponsored sports team.

15. Lipectomy.

16. Prescription Drugs, services or supplies as follows:
• Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
• Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
• Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs.
• Products used for cosmetic purposes.
• Drugs used to treat or cure baldness. Anabolic steroids used for body building.
• Anorectics - drugs used for the purpose of weight control.
• Fertility agents, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene.
• Growth hormones, except to treat children with growth failure due to a pituitary disorder.
• Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

17. Reproductive/Infertility services including but not limited to the following:
• 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.
• Sexual reassignment surgery.

18. 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 for Approved Clinical Trials.

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 the first pair of eyeglasses or contact lenses following cataract surgery which must be purchased within 90 days following surgery.

20. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
21. Preventive care services, except as 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.
22. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
23. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Temporomandibular joint dysfunction. Deviated nasal septum, including submucous resection and/or other surgical correction thereof.
24. 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.
25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
27. 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).
28. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

UnitedHealthcare Global: Global Emergency Services

If you are a member insured with this insurance plan, you are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International students: You are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

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

Key Services include:
- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services
Please visit www.myameriben.com/uofi.htm for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

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

Services are also accessible via e-mail at assistance@UHCGlobal.com.

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

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

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Clinic for treatment, or when not in school, to their Physician or Hospital.

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

3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

AmeriBen
PO Box 7186
Boise, ID 83707
Fax 1-208-424-0595
www.myameriben.com/uofi.htm
Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

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

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

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

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 1-800-953-1801 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured’s ID card.

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

Covered Dental Services

Benefits are eligible for Covered Dental Services if such Dental Services are 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.

Pre-Treatment Estimate

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

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

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

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 rendered. 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 Services exclusions.

Dental Services Deductible

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

Out-of-Pocket Maximum

Any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this benefit 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.

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</th>
<th>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intraoral Bitewing Radiographs (Bitewing X-ray)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 2 series of films per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>(Full Set of X-rays) Limited to 1 time per 36 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodic Oral Evaluation (Check up Exam)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cephalometric X-ray</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Prophylaxis (Cleanings)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 2 times per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatments</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants (Protective Coating)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to once per first or second permanent molar every 36 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers (Spacers)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Benefit includes all adjustments within 6 months of installation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Description and Limitations</td>
<td>Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Minor Restorative Services, Endodontics, Periodontics and Oral Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amalgam Restorations (Silver Fillings)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Multiple restorations on one surface will be treated as a single filling.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Resin Restorations (Tooth Colored Fillings)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>For anterior (front) teeth only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics (Root Canal Therapy)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Periodontal Surgery (Gum Surgery)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 quadrant or site per 36 months per surgical area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scaling and Root Planing (Deep Cleanings)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per quadrant per 24 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Periodontal Maintenance (Gum Maintenance)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Exxtractions (Simple tooth removal)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per lifetime.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery, including Surgical Extraction</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Adjunctive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Services (including Dental Emergency treatment)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Covered as a separate benefit only if no other service was done during the visit other than X-rays.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General anesthesia is covered when clinically necessary.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occlusal guards limited to 1 guard every 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Restorative Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inlays/Onlays/Crowns (Partial to Full Crowns)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Prosthetics (Bridges)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removable Prosthetics (Full or partial dentures)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relining and Rebasing Dentures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Placement</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Supported Prosthetics</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Maintenance Procedures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Benefit Description and Limitations

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Repair Implant Abutment by Support Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

#### MEDICALLY NECESSARY ORTHODONTICS

Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; 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. All orthodontic treatment must be prior authorized.

**Orthodontic Services**

Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be Medically Necessary.

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Services</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

### 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 in the treatment of that particular condition.
9. Drugs/medications, obtainable 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 failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
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. Foreign Services are not covered unless required for a Dental Emergency.

19. Fixed or removable prosthetic restoration procedures for complete oral rehabilitation or reconstruction.

20. Procedures related to the reconstruction of a patient’s correct vertical dimension of occlusion (VDO).

21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.

22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24. 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 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:

AmeriBen
P.O. Box 7186
Boise, ID 83707

Submit claims for payment within 90 days after the date of service. If the Insured doesn’t provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-800-953-1801. This number is also listed on the Insured's Dental ID Card.
Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

Dental Provider - any dentist, denturist 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.

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

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

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 in this rider. The definition of Necessary used in this rider relates only to benefits under this rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

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.

**Pediatric Vision Care Services Benefits**

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

**Section 1: Benefits for Pediatric Vision Care Services**

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-800-953-1801. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person 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 Spectera Eyecare Networks 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.

**Policy Deductible**

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

**Benefit Description**

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

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

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

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

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

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

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

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

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

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

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

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.
Low Vision – Benefits are available to an Insured Person who has severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company.

This benefit includes:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

**Schedule of Benefits**

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination or Refraction only in lieu of a complete exam.</td>
<td>Once per year.</td>
<td>100% after a Copayment of $20.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass Lenses</td>
<td>Once per year.</td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Single Vision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bifocal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trifocal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenticular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lens Extras</td>
<td>Once per year.</td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard scratch-resistant coating</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass Frames</td>
<td>Once per year.</td>
<td>100%</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost up to $130.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost of $130 - 160.</td>
<td></td>
<td>100% after a Copayment of $15.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost of $160 - 200.</td>
<td></td>
<td>100% after a Copayment of $30.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost of $200 - 250.</td>
<td></td>
<td>100% after a Copayment of $50.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Eyeglass frames with a retail cost greater than $250.</td>
<td></td>
<td>60%</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Limited to a 12 month supply.</td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Necessary Contact Lenses</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
</tbody>
</table>

**Low Vision Services**

Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.

<table>
<thead>
<tr>
<th></th>
<th>Once every 24 months.</th>
<th>100% of the billed charge.</th>
<th>75% of the billed charge.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Vision Testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Vision Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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 Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), the Insured Person must provide all of the following information at the address specified below:

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

Submit the above information to the Company:

By mail:
AmeriBen
P.O. Box 7186
Boise, ID 83707

Reimbursement for Low Vision Services

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

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

Submit the above information to the Company:

By mail:
AmeriBen
P.O. Box 7186
Boise, ID 83707

Submit claims for payment within 90 days after the date of service. If the Insured doesn’t provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.
Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

### Notice of Appeal Rights

**RIGHT OF INTERNAL REVIEW**

#### 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 1-800-953-1801 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: AmeriBen, P.O. Box 7186, Boise, ID 83707.

#### Expedited Internal Appeal

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

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 1-800-953-1801. The written request for an Expedited Internal Appeal should be sent to: AmeriBen, P.O. Box 7186, Boise, ID 83707.

You, the Insured, will be notified in writing by us if a claim or any part of a claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent plan provision(s) on which the denial was based.

If you have a complaint about your claim denial, you may call our Member Services telephone number 1-800-953-1801 for further explanation to informally resolve your complaint. If you are not satisfied with our explanation of why the claim was denied, you, your authorized representative or provider may request an internal review of the claim denial.
RIGHT TO EXTERNAL REVIEW

If, through the Company’s internal appeal process, the Insured or any Authorized Representative acting on behalf of the Insured with the Insured’s consent, has exhausted the internal mechanism for appealing a denial of benefits based on Medical Necessity or has been determined to be an investigational service, the Insured or Authorized Representative may file a written request for an external review and, in certain circumstances, expedited external review with the Director of the Idaho Department of Insurance.

When filing a request for external review, an Insured will be required to authorize the release of any medical records that may be required for the purpose of reaching a decision. This plan is not subject to ERISA; as a result, the external review decision of the independent review organization shall be final and binding on both the Insured and the Company as provided in section 41-5910 of the Idaho Insurance Code.

For further information about the External Review or to request an external review, contact the Idaho Department of Insurance in writing at P.O. Box 83720; Boise, ID 83720-0433 or by telephone at 1-800-721-3272.
The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Submit all Claims or Inquiries to:
AmeriBen
P.O. Box 7186
Boise, ID 83707
1-800-953-1801
Group#0805014

Sales/Marketing Services:
UnitedHealthcare StudentResources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
800-237-0903
E-mail: info@uhcsr.com

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

This Certificate is based on Policy number: 2016-353-4.

Contact information for the Idaho Department of Insurance:
Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043
Phone: (800) 721-3272 or (208) 334-4250
Website: www.DOI.Idaho.gov