2012-2013

Student Injury and Sickness Insurance Plan

Designed especially for the students of:

Connecticut Community-Technical Colleges

This Certificate does not provide Coverage for:
Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; Injury sustained while (a) participating in any intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition.

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.
Notice Regarding Your Student Health Insurance Coverage

This Student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. This student health insurance coverage puts a policy year limit of $100,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-767-0700. Be advised that an Insured Person may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if an Insured Person is under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

Eligibility

All enrolled students are eligible to enroll in the Optional 24-Hour Injury and Sickness Plan on a voluntary basis. Eligible Dependents of students enrolled in the Optional plan may also enroll on a voluntary basis.
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility and Termination Provisions</td>
<td>2</td>
</tr>
<tr>
<td>General Provisions</td>
<td>2</td>
</tr>
<tr>
<td>Definitions</td>
<td>4</td>
</tr>
<tr>
<td>Schedule of Benefits</td>
<td>10</td>
</tr>
<tr>
<td>Benefit Provisions</td>
<td>14</td>
</tr>
<tr>
<td>Mandated Benefits</td>
<td>18</td>
</tr>
<tr>
<td>Exclusions and Limitations</td>
<td>27</td>
</tr>
</tbody>
</table>
PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the Named Insured actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

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

1) If a Named Insured has Dependents on the date he or she is eligible for insurance; or
2) If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
   (a) On the date the Named Insured marries or enters into a civil union with the Dependent; or
   (b) On the date the Named Insured acquires a dependent child who is within the limits of a dependent child set forth in the "Definitions" section of this policy.

Dependent eligibility expires concurrently with that of the Named Insured.

Eligible persons may be insured under this policy subject to the following:

1) Payment of premium as set forth on the policy application; and,
2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

1) The Effective Date of the policy; or
2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Named Insured.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid; or
2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

1) The last day of the period through which the premium is paid;
2) The date the policy terminates; or
3) The date the Named Insured's coverage terminates.

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.
PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company, P.O. Box 809026, Dallas, Texas 75380-9026.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

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

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

PAYMENT OF CLAIMS: All or a portion of any indemnities provided by this policy may, at the Company's option, and unless the Named Insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such service. Otherwise, accrued indemnities will be paid to the Named Insured or the estate of the Named Insured. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

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

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

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.
MORE THAN ONE POLICY: Insurance effective at any one time on the Insured Person under a like policy, or policies in this Company is limited to the one such policy elected by the Insured Person, his beneficiary or his estate, as the case may be, and the Company will return all premiums paid for all other such policies.

PART III
DEFINITIONS

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

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

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 endorsement 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.

DEPENDENT means the spouse (including a party to a civil union established according to Connecticut law) of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years. The policy shall cover a stepchild on the same basis as a biological child.

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

1) Incapable of self-sustaining employment by reason of mental or physical handicap.
2) Chiefly dependent upon the Insured Person for support and maintenance.

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

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).
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. Experimental treatment does not include a procedure, treatment or the use of any Drug as experimental if such procedure, treatment or drug, for the Sickness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.

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

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

INJURY means accidental bodily injuries sustained by the Insured Person which: 1) are the direct cause, independent of disease or bodily infirmity or any other cause; 2) are treated by a Physician within 30 days after the date of accident; and occurs while this policy is in force, subject to the policy Pre-existing Condition provisions. 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, subject to the policy Pre-existing Condition provisions.

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

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

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

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

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** means health care services that a Physician, exercising prudent clinical judgement, would provide to an Insured for the purpose of preventing, evaluating, diagnosing or treating Sickness, Injury, or its symptoms, and that are:

1. In accordance with Generally Accepted Standards of Medical Practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured’s Sickness or Injury; and
3. Not primarily for the convenience of the Insured, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Insured’s Sickness or Injury.

For the purposes of this definition, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgement.

**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. Mental illness does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorder, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders*. 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** means: 1) a newly born child of the Insured from the moment of birth provided that person is insured under this policy; 2) a child adopted by the Insured provided the person adopting the child is insured under this policy on the date the adoption becomes effective; and 3) a child who has been placed for adoption with the Insured, even though the adoption has not been finalized, provided the child lives in the household of the Insured and is dependent upon the Insured for support and maintenance. Such child will be covered under the policy for the first 61 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; and 3) the date of placement of the child for adoption. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 61 days. To continue the coverage the Insured must, within the 61 days after the child's birth: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 61 days after the child's birth.

**OCCUPATIONAL THERAPY** means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a duly licensed Physician who has certified that the prescribed care and treatment are not available from sources other than a licensed occupational therapist and which are provided in private practice or in a licensed health care facility. Such plan shall be reviewed and certified at least every two months by such Physician. "Health care facility" means an institution which provides occupational therapy, including, but not limited to, an outpatient clinic, a rehabilitative agency and a skilled or intermediate nursing facility.
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 according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

1) Deductibles.
2) Copays.
3) Expenses that are not Covered Medical Expenses.

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.

PHYSIOTHERAPY means any form of the following short-term rehabilitation therapies: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

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

[PRE-EXISTING CONDITION means any condition which is diagnosed, treated or recommended for treatment within the [12] months immediately prior to the Insured's Effective Date under the policy. Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a pre-existing condition.]

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.

QUALIFYING COVERAGE means: 1) any group health insurance plan, insurance arrangement or self-insured plan; 2) Medicare or Medicaid; or 3) an individual health insurance plan that provides benefits that are actuarially equivalent to or exceeding the benefits provided under the small employer health care plan as defined by the state, whether issued in the state of Connecticut or any other state.

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, and originates while the Insured Person is covered under this policy, subject to the policy Pre-existing Condition provisions. 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.

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 class. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.
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 of the Policyholder. 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.
PART IV

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this 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.
PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
CONNECTICUT COMMUNITY-TECHNICAL COLLEGES - STUDENT PLAN
2012-201337-2
INJURY AND SICKNESS BENEFITS

Maximum Benefit $100,000 (Per Insured Person) (Per Policy Year)
Deductible Preferred Providers $1,000 (Per Insured Person, Per Policy Year)
Deductible Out of Network $2,000 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Providers 80% except as noted below
Coinsurance Out of Network 60% except as noted below
Out-of-Pocket Maximum Preferred Providers $10,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out of Network $15,000 (Per Insured Person, Per Policy Year)

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% up to the policy Maximum Benefit subject to any benefit maximums that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. The policy Deductible, Copays and per service Deductibles and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. 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.

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Intensive Care:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Hospital Miscellaneous:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Routine Newborn Care:</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>(See also Benefits for Postpartum Care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Surgery:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Assistant Surgeon:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Registered Nurse's Services:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician's Visits:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Pre-admission Testing:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Day Surgery Miscellaneous:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician's Visits:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physiotherapy:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Medical Emergency:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

(Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.)
<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-rays:</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:</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>*Prescription Drugs:</td>
<td>UnitedHealthcare Network Pharmacy (UHPS)</td>
<td>$15 Deductible per prescription for generic drugs</td>
</tr>
<tr>
<td></td>
<td>$15 Copay per prescription for Tier 1</td>
<td>$35 Deductible per prescription for brand name</td>
</tr>
<tr>
<td></td>
<td>$35 Copay per prescription for Tier 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$40 Copay per prescription for Tier 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>up to a 31-day supply per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(*Mail order Prescription Drugs through UHPS at 2.5 times the retail copay up to a 90 day supply.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance:</td>
<td>Maximum allowable rate established by the Department of Public Health</td>
<td>Maximum allowable rate established by the Department of Public Health</td>
</tr>
<tr>
<td>Durable Medical Equipment:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td></td>
<td>($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum Per Policy Year are not included in the $100,000 Maximum Benefit.)</td>
<td></td>
</tr>
<tr>
<td>Consultant:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Dental:</td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td></td>
<td>($1,000 maximum Per Policy Year)(Benefits paid on Injury to Sound, Natural Teeth only. Benefits are not subject to the $100,000 Maximum Benefit.)</td>
<td></td>
</tr>
<tr>
<td>Maternity:</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td></td>
<td>(See also Benefits for Postpartum Care)</td>
<td></td>
</tr>
<tr>
<td>Elective Abortion:</td>
<td>No Benefits</td>
<td>No Benefits</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>Repatriation:</td>
<td>Benefits provided by Scholastic Emergency Services, Inc.</td>
<td>Benefits provided by Scholastic Emergency Services, Inc.</td>
</tr>
<tr>
<td>Medical Evacuation:</td>
<td>Benefits provided by Scholastic Emergency Services, Inc.</td>
<td>Benefits provided by Scholastic Emergency Services, Inc.</td>
</tr>
</tbody>
</table>

| *AD&D:                        | ($1,250 - $5,000 maximum)                                                          |                                                                                        |
| Home Health Care:             | See Benefits for Home Health Care                                                   | See Benefits for Home Health Care                                                     |
| Preventive Care Services:     | 100% of Preferred Allowance                                                        | No Benefits                                                                             |
|                                | (No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.) |                                                                                        |
| Diabetes Services:            | Paid as any other Sickness                                                         | Paid as any other Sickness                                                             |
|                                | (See Benefits for Diabetes and Benefits for Diabetic Outpatient Self-Management Training) |                                                                                        |
| Mental Illness Treatment:     | Paid as any other Sickness                                                         | Paid as any other Sickness                                                             |
|                                | (See also Benefits for Mental or Nervous Conditions)                               |                                                                                        |
| Reconstructive Surgery Following | Note Below                                                                       | Note Below                                                                              |
| Mastectomy:                   | Paid as any other Sickness                                                         | Paid as any other Sickness                                                             |
|                                | (See Benefits for Reconstructive Breast Surgery)                                   |                                                                                        |
| Substance Use Disorder Treatment: | Paid as any other Sickness                                                       | Paid as any other Sickness                                                             |
|                                | (See also Benefits for Mental or Nervous Conditions)                              |                                                                                        |

| MAJOR MEDICAL                  |                                                                                   |                                                                                        |
|--------------------------------|------------------------------------------------------------------------------------|                                                                                        |
| Maximum Benefit                |                                                                                   |                                                                                        |
| No Benefits                    |                                                                                   |                                                                                        |
CATASTROPHIC MEDICAL

Maximum Benefit  No Benefits

SHC Referral Required: Yes ( ) No (X)  Continuation Permitted: Yes ( ) No (X)

( ) 52 Week Benefit Period  or  (X) Extension of Benefits

*Pre Admission Notification: Yes (X) No ( )

Other Insurance:  ( ) Excess Insurance  (X) Excess Motor Vehicle Only  (X) Primary Insurance

*If benefit is designated, see endorsement attached.
53. PART VI
54. PREFERRED PROVIDER INFORMATION

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

UnitedHealthcare Choice Plus

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 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. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call (800) 767-0700 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

24.
PART VII
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

25. 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 Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any Coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. 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:

2. **Room and Board Expense:** 1) daily semi-private room rate when confined as an Inpatient; and 2) general nursing care provided and charged by the Hospital.

3. **Intensive Care:** If provided in the Schedule of Benefits.

4. **Hospital Miscellaneous Expenses:** 1) when confined as an Inpatient; or 2) as a precondition for being confined as an Inpatient. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; therapeutic services; and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

5. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames. See also Benefits for Postpartum Care.

6. **Physiotherapy (Inpatient):** See Schedule of Benefits. See also Benefits for Occupational Therapy.

7. **Surgery:** Physician's fees for Inpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.

8. **Assistant Surgeon Fees:** in connection with Inpatient surgery, if provided in the Schedule of Benefits.

9. **Anesthetist Services:** professional services administered in connection with Inpatient surgery.

10. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while an Inpatient; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.

11. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the Inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.

12. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.

13. **Surgery (Outpatient):** Physician's fees for outpatient surgery. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.
14. **Day Surgery Miscellaneous (Outpatient):** 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. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.

15. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

16. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.

17. **Physician's Visits (Outpatient):** benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the Inpatient benefit for Physician's Visits, but not both on the same day. Physician’s Visits for preventive care are provided as specified under Preventive Care Services.

18. **Physiotherapy (Outpatient):** benefits are limited to one visit per day. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) Occupational Therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Occupational Therapy.

19. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.

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


22. **Laboratory Procedures (Outpatient):** See Schedule of Benefits. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

23. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit: inhalation therapy; infusion therapy; pulmonary therapy; and respiratory therapy. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

24. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

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

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

27. **Ambulance Services:** Medically Necessary transport. See Schedule of Benefits.

28. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. Durable medical equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. If more than one prosthetic device can meet the Insured’s functional need, benefits are available only for the prosthetic device that meets the minimum specifications for the Insured’s needs. 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.

29. **Consultant Physician Fees:** when requested and approved by the attending Physician.
30. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. See also Benefits for Inpatient Dental Services.

31. **Mental Illness Treatment:** Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; and 2) on an outpatient basis including intensive outpatient treatment. Benefits are limited to one visit per day. See also Benefits for Mental or Nervous Conditions.

32. **Substance Use Disorder Treatment:** Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; 2) on an outpatient basis including intensive outpatient treatment. Benefits are limited to one visit per day. See also Benefits for Mental or Nervous Conditions.

33. **Maternity:** Same as any other Sickness. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. See also Benefits for Postpartum Care.

34. **Complications of Pregnancy:** Same as any other Sickness.

35. **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: 1) 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; 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3) 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; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

36. **Reconstructive Breast Surgery Following Mastectomy:** See Benefits for Reconstructive Breast Surgery.

37. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes and Benefits for Diabetic Outpatient Self-Management Training.

38. **Home Health Care:** See Benefits for Home Health Care.

39. **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. See Benefits for Clinical Trial.

40. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

41. **Medical Evacuation:** 1) when Hospital Confined for at least five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Major Medical coverage.

42. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.
55. PART VIII
MANDATED BENEFITS

56. BENEFITS FOR ACCIDENTAL INGESTION OF A CONTROLLED DRUG

Benefits will be paid for accidental ingestion or consumption of a controlled drug as required by Connecticut statute. When Inpatient treatment in a Hospital, whether or not operated by the State, is required as a result of accidental ingestion or consumption of a controlled drug, benefits will be paid for the Usual and Customary Charges incurred up to a maximum of 30 days Hospital Confinement. Benefits will also be paid for outpatient treatment resulting from accidental ingestion or consumption of a controlled drug for any one accident.

57. BENEFITS FOR HYPODERMIC NEEDLES OR SYRINGES

Benefits will be paid for the Usual and Customary Charges incurred for hypodermic needles or syringes prescribed by a licensed Physician for the purpose of administering medications for any Injury or Sickness, provided such medications are covered under the policy.

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

58. 26. BENEFITS FOR HOME HEALTH CARE

27. 28. Benefits will be paid as specified below for Injury or Sickness for home health care to residents in Connecticut.

29. 30. Benefits payable shall be limited to eighty visits in any calendar year or in any continuous period of twelve months for each Insured. Each visit by a representative of a home health agency shall be considered as one Home Health Care visit; four hours of home health aide service shall be considered as one Home Health Care visit.

31. 32. Home Health Care benefits are subject to an annual Deductible of fifty dollars ($50.00) for each Insured and will be subject to a Coinsurance provision of not less than seventy-five per cent (75%) of the Usual and Customary Charges for such services. If an Insured is eligible for Home Health Care coverage under more than one policy, the Home Health Care benefits shall only be provided by that Policy which would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized.

33. 34. “Home Health Care” means the continued care and treatment of an Insured Person who is under the care of a Physician if:

(1) continued hospitalization would otherwise have been required if Home Health Care was not provided, except in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of six months or less to live, and,

(2) the plan covering the Home Health Care is established and approved in writing by such Physician within seven days following termination of a hospital confinement as a resident Inpatient for the same or a related condition for which the Insured was hospitalized, except that in the case of an Insured diagnosed by a Physician as terminally ill with a prognosis of six months or less to live, such plan may be so established and approved at any time irrespective of whether such Insured was so confined or, if such Insured was so confined, irrespective of such seven-day period, and

(3) such Home Health Care is commenced within seven days following discharge, except in the case of a covered person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live.

35. 36. Home Health Care shall be provided by a home health agency. “Home health agency” means an agency or organization which meets each of the following requirements:

(1) It is primarily engaged in and is federally certified as a home health agency and duly licensed by the appropriate licensing authority to provide nursing and other therapeutic services.

(2) Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one Registered Nurse, to govern the services provided.

(3) It provides for full-time supervision of such services by a Physician or by a Registered Nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an administrator.
37. Home Health Care shall consist of, but shall not be limited to, the following:
   (1) Part-time or intermittent nursing care by a Registered Nurse or by a licensed practical nurse under the supervision of a
       Registered Nurse, if the services of a Registered Nurse are not available;
   (2) Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature
       by other than a Registered Nurse or licensed practical nurse;
   (3) Physical, occupational or speech therapy;
   (4) Medical supplies, drugs and medicines prescribed by a Physician and laboratory services to the extent such charges would
       have been covered under the Policy or contract if the Insured had remained or had been confined in the Hospital;
   (5) Medical social services provided to or for the benefit of a covered person diagnosed by a Physician as terminally ill with a
       prognosis of six months or less to live. “Medical social services” mean services rendered, under the direction of a
       Physician by a qualified social worker, including but not limited to:
           (A) assessment of the social, psychological and family problems related to or arising out of such covered person’s
               illness and treatment;
           (B) appropriate action and utilization of community resources to assist in resolving such problems;
           (C) participation in the development of the overall plan of treatment for such Insured.

38. Benefits shall be subject to all other limitations and provisions of the policy.

40. BENEFITS FOR MENTAL OR NERVOUS CONDITIONS

41. Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Mental Illness and Substance Use
    Disorders.

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

59. BENEFITS FOR TREATMENT OF TUMORS AND LEUKEMIA

Benefits will be paid the same as any other Sickness for the surgical removal of tumors and for treatment of leukemia, including
outpatient chemotherapy, reconstructive surgery, cost of any non-dental prosthesis, including any maxillofacial prosthesis used
to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of
such prosthesis and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, and a wig
if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.

Benefits Per Policy Year shall be at least $300.00 for prosthesis, except that for purposes of the surgical removal of breasts due
to tumors the yearly benefit for prosthesis shall be at least $300.00 for each breast removed, and $350.00 for a wig.

If the policy provides benefits for Prescription Drugs, benefits will be provided for prescribed orally administered anticancer
medications on a basis that is no less favorable than intravenously administered anticancer medications.

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY

46. Benefits will be paid for the Usual and Customary Charges incurred for reconstructive surgery on each breast on which a
    mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance.
    Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

47. Benefits shall be provided for at least forty eight hours of Inpatient care following a mastectomy or lymph node dissection,
    and may provide for a longer period of Inpatient care if such care is recommended by the Insured’s Physician.

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

BENEFITS FOR MAMMOGRAPHY AND COMPREHENSIVE ULTRASOUND SCREENING

Benefits will be paid the same as any other Covered Medical Expenses as shown on the Schedule of Benefits for mammographic
examinations to any woman insured under this policy which are equal to the following requirements: 1) a baseline mammogram
for any woman who is thirty-five to thirty-nine years of age, inclusive; and 2) a mammogram every year for any woman who is
forty years of age or older.

Additional benefits will be provided for comprehensive ultrasound screening and magnetic resonance imaging, in accordance
with guidelines established by the American Cancer Society or the American College of Radiology, of an entire breast or breasts
if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System
established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to
family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman’s
Physician or advanced practice Registered Nurse.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.
52. BENEFITS PROSTATE CANCER TESTING

53. Benefits will be paid the same as any other Sickness for laboratory and diagnostic tests, including, but not limited to, prostate specific antigen (PSA) tests to screen for prostate cancer for Insureds who are symptomatic, or whose biological father or brother has been diagnosed with prostate cancer, and for all Insureds fifty (50) years of age or older.

54. Benefits will also be paid for the treatment of prostate cancer, provided such treatment is Medically Necessary and in accordance with guidelines established by the National Comprehensive Cancer Network, the American Cancer Society or the American Society of Clinical Oncology.

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

56. BENEFITS FOR OSTOMY APPLIANCES AND SUPPLIES

57. Benefits will be paid for the Usual and Customary Charges for Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors up to a maximum benefit of $2,500.00 per Policy Year.

58. “Ostomy” shall include colostomy, ileostomy and urostomy.

59. Benefits shall not be applied to any Durable Medical Equipment benefit maximum. Benefits shall be subject to all other Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.

60. BENEFITS FOR COLORECTAL CANCER SCREENING

61. Benefits will be paid the same as any other Sickness for colorectal cancer screening, including, but not limited to: (1) an annual fecal occult blood test, and (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after their consultation with the American Cancer Society and the American College of Radiology, based on the ages, family histories and frequencies provided in the recommendations.

62. “Routine Patient Care Costs” means: 1) Medically Necessary health care services that are incurred as a result of treatment being provided to the Insured for purposes of the Clinical Trial that would otherwise be covered if such services were not rendered pursuant to a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Insured during the course of treatment in the Clinical Trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the Insured were not enrolled in a Clinical Trial; and 2) costs incurred for Prescription Drugs provided to the Insured, provided such Prescription Drugs have been approved for sale by the federal Food and Drug Administration. If the policy provides Preferred Provider benefits, such hospitalization shall include treatment at an Out-of-Network facility if such treatment is not available at a Preferred Provider Hospital and not eligible for reimbursement by the sponsors of such Clinical Trial.

63. Routine Patient Care Costs shall not include: 1) the cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration; 2) the cost of a non-health care service that an Insured may be required to receive as a result of the treatment being provided; 3) facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial; 4) costs of services that are: a) inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis; or b) performed specifically to meet the requirements of the Clinical Trial; 5) costs that would not be covered under the Insured’s policy for investigational treatments, including, but not limited to, items excluded from coverage under this policy; and 6) transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial for the Insured or any family member or companion.
The Company may require that the person or entity seeking coverage for the Clinical Trial provide: 1) evidence satisfactory to the Company that the Insured receiving coverage meets all of the patient selection criteria for the clinical trial, including credible evidence in the form of clinical or pre-clinical data showing that the Clinical Trial is likely to have a benefit for the Insured Person that is commensurate with the risks of participation in the Clinical Trial to treat the Insured Person’s condition; and 2) evidence that the appropriate informed consent has been received from the Insured; and 3) copies of any medical records, protocols, test results or other clinical information used by the Physician or institution seeking to enroll the Insured in the Clinical Trial; and 4) a summary of the anticipated Routine Patient Care Costs in excess of the costs for standard treatment; and 5) information from the Physician or institution regarding those items, including any Routine Patient Care Costs, that are eligible for reimbursement by an entity other than the Company, including the entity sponsoring the Clinical Trial; and 6) any additional information that may be reasonably required for the review of a request for coverage of the Clinical Trial. The Company shall request any additional information about a Clinical Trial not later than five business days after receiving a request for coverage from an Insured Person or a Physician seeking to enroll an Insured in a Clinical Trial.

65. A Clinical Trial for the prevention of cancer shall be eligible for coverage only if it involves a therapeutic intervention, is a phase III Clinical Trial approved by one of the entities identified below and is conducted at multiple institutions. In order to be eligible for coverage of Routine Patient Care Costs, a Clinical Trial shall be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: 1) one of the National Institutes of Health; or 2) a National Cancer Institute affiliated cooperative group; or 3) the federal Food and Drug Administration as part of an investigational new drug or device exemption; or 4) the federal Department of Defense or Veterans Affairs; or 5) qualified to receive Medicare coverage of its routine costs under the Medicare Clinical Trial Policy established under the September 19th, 2000, Medicare National Coverage Determination, as amended from time to time. Benefits will not be provided for any single institution Clinical Trial conducted solely under the approval of the institutional review board of an institution, or any trial that is no longer approved by an entity identified herein.

The provider, Hospital or institution seeking coverage for the Routine Patient Care Costs shall submit to the Company the standardized request for coverage form as developed by the Connecticut Insurance Department to request approval for Clinical Trial benefits. The Company shall not accept any other approval request form other than the standardized request for coverage form. Upon receipt of the standardized form, the Company shall approve or deny coverage for such services not later than five business days after receiving such request and any other reasonable supporting materials requested by the Company, except that if the Company utilizes independent experts to review such requests, it shall respond not later than ten business days after receiving such request and supporting materials.

The Insured, or the provider with the Insured’s written consent, may appeal any denial of coverage for Medical Necessity to an external, independent review pursuant to section 39a-478n of the general statutes. Such external review shall be conducted by a properly qualified review agent whom the Connecticut Department of Insurance has determined does not have a conflict of interest regarding the Clinical Trial.

The Company shall not provide coverage for Routine Patient Care Costs that are eligible for reimbursement by an entity other than the Company, including the entity sponsoring the Clinical Trial.

Routine Patient Care Costs shall be subject to the same Deductibles, Copayments, Coinsurance, terms, conditions, restrictions, exclusions and limitations of the policy, including limitations on out-of-network care, except that treatment at an out-of-network Hospital shall be made available by the out-of-network Hospital and the Company at no greater cost to the Insured than if treatment was available at a Preferred Provider Hospital.

**BENEFITS FOR POSTPARTUM CARE**

If an Insured and Newborn Infant are discharged from Inpatient care less than forty-eight hours after a vaginal delivery or less than ninety-six hours after a cesarean delivery, benefits will be provided on the same basis as any other Covered Medical Expenses as shown on the Schedule of Benefits for a follow-up visit within forty-eight hours of discharge and an additional follow-up visit within seven days of discharge. Any decision to shorten the length of Inpatient stay to less than forty-eight hours after a vaginal delivery or ninety-six hours after a cesarean delivery shall be made by the Physician after conferring with the Insured.
Follow-up services shall include, but not be limited to, physical assessment of the Newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any Medically Necessary and appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and Newborn pediatric care.

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

68. BENEFITS FOR AMINO ACID MODIFIED PREPARATIONS AND LOW PROTEIN MODIFIED FOOD PRODUCTS

69. Benefits will be paid the same as any other outpatient Prescription Drug for Amino Acid Modified Preparations and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if the Amino Acid Modified Preparations or Low Protein Modified Food Products are prescribed for the therapeutic treatment of Inherited Metabolic Diseases and are administered under the direction of a Physician.

70. If the policy does not provide benefits for outpatient Prescription Drugs, benefits will be provided subject to the policy maximum benefit including any Deductible, Copayment or Coinsurance requirements.

71. “Inherited Metabolic Disease” means: (A) disease for which newborn screening is required under Connecticut Statute Title 38a, Chapter 700c, Section 19a-55; and (B) Cystic Fibrosis.

72. “Low Protein Modified Food Product means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.

73. “Amino Acid Modified Preparation” means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

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

82. BENEFITS FOR SPECIALIZED FORMULAS

83. Benefits will be paid the same as any other outpatient Prescription Drug for medically necessary Specialized Formulas for Dependent children up to age twelve when such specialized formulas are for the treatment of a condition for which newborn screening is required under section 19a-55 of the Public Health and Well Being Regulation.

84. If the policy does not provide benefits for outpatient Prescription Drugs, benefits will be provided subject to the policy maximum benefit including any Deductible, Copayment or Coinsurance requirements.

85. “Specialized Formula” means a nutritional formula for children up to age twelve that is exempt from the general requirement for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific disease.

86. Benefit shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.

92. BENEFITS FOR DIABETES

93. Benefits will be paid the same as any other Sickness for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include Medically Necessary equipment, in accordance with the Insured Person’s treatment plan, drugs and supplies prescribed by a Physician.

94. If the policy contains a Prescription Drugs maximum benefit, diabetic insulin and supplies shall not be subject to the Prescription Drugs maximum benefit specified in the Schedule of Benefits. Benefits shall be subject to all other Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.
95. BENEFITS FOR DIABETIC OUTPATIENT SELF-MANAGEMENT TRAINING

96. Benefits will be paid the same as any other Sickness for outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a Physician. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a Physician, as defined in the Policy, trained in the care and management of diabetes and authorized to provide such care within the scope of the Physician’s practice.

Covered Medical Expenses shall include:
1) Initial training visits provided to an Insured after the Insured is initially diagnosed with diabetes that is Medically Necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, up to a maximum of ten hours.
2) Training and education that is Medically Necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Insured’s symptoms or condition which requires modification of the Insured’s program of self-management of diabetes, up to a maximum of four hours.
3) Training and education that is Medically Necessary because of the development of new techniques and treatment for diabetes up to a maximum of four hours.

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

99.
100. BENEFITS FOR LYME DISEASE TREATMENT

101. Benefits will be paid the same as any other Sickness for Lyme disease treatment including not less than thirty days of intravenous antibiotic therapy, sixty days of oral antibiotic therapy, or both, and shall provide benefits for further treatment if recommended by a Physician.

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

BENEFITS FOR INPATIENT DENTAL SERVICES

105. Benefits will be paid the same as any other Sickness for general anesthesia, nursing and related Hospital services provided in conjunction with Inpatient, outpatient or one day dental services if the following conditions are met:

1) The anesthesia, nursing and related Hospital services are deemed Medically Necessary by the treating Physician.
2) The Insured is either a) a person who is determined by a Physician to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a Hospital, or b) a person who has a developmental disability, as determined by a Physician, that places the person at serious risk.

The expense of anesthesia, nursing and related Hospital services shall be deemed a Covered Medical Expense and shall not be subject to any limits on dental benefits in the Policy.

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

108. BENEFITS FOR TREATMENT OF CRANIOFACIAL DISORDERS

109. Benefits will be paid the same as any other Sickness for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Insureds eighteen years of age or younger. The processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No benefits are provided for cosmetic surgery.

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

BENEFITS FOR PAIN MANAGEMENT

Benefits will be paid the same as any other Sickness for Pain treatment ordered by a Pain Management Specialist, which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

“Pain” means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves, and “Pain Management Specialist” means a Physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

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

115. BENEFITS FOR ISOLATION CARE AND EMERGENCY SERVICES

116. Benefits will be paid the same as any other Injury or Sickness for isolation care and emergency services provided by the state’s mobile field Hospital.

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

120.
121. BENEFITS FOR INFERTILITY TREATMENT

64. Benefits will be paid the same as any other Sickness for an Insured Person for the medically necessary expenses of the diagnosis and treatment of Infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer. Such infertility treatment must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

65. Benefits for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer, and tubal ovum transfer are payable only to those Insured Persons who:
   a) Have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered by this policy. However benefits will not be denied on this basis for any Insured Person who foregoes a particular infertility treatment or procedure if the Insured Person’s Physician determines that such treatment or procedure is likely to be unsuccessful.
   b) Have been covered under the school’s student insurance policy for at least 12 months.
   c) Provide disclosure of any previous infertility treatment or procedures for which such Insured Person received coverage under a different health insurance policy.

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

122. BENEFITS FOR EARLY INTERVENTION SERVICES

Benefits will be paid as determined by the schedule published by the Director of Connecticut’s Birth to Three program for Medically Necessary Early Intervention Services for Dependent Eligible Children, from birth until the child’s third birthday, that are provided as part of an Individualized Family Service Plan pursuant to Title 17a of the Social and Human Services and Resources, Chapter 319b, Department of Developmental Services, section, 17a-248e, up to a maximum benefit of $6,400.00 per child per calendar year and an aggregate benefit of $19,200.00 per child over the total three-year period. Benefits paid under this benefit shall not be applied to any Policy Year maximum specified in the Policy. To the extent that an Early Intervention Service falls into one of the essential benefit categories issued by the Affordable Care Act (ACA) the maximum and aggregate benefit limit will not be applied.

"Early intervention services" means early intervention services, as defined in 34 CFR Part 303.12, as from time to time amended.

"Eligible children" means Dependent children from birth to thirty-six months of age, who are not eligible for special education and related services pursuant to sections 10-76a to 10-76h, inclusive, as amended, and who need Early Intervention Services because such children are: (A) Experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas: (1) cognitive development; (2) physical development, including vision or hearing; (3) communication development; (4) social or emotional development; or (5) adaptive skills; or (B) Diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay.

"Individualized family service plan" means a written plan for providing Early Intervention Services to an Eligible Child and the child's family after completion of an evaluation.

"Evaluation" means a multidisciplinary professional, objective assessment conducted by appropriately qualified personnel in order to determine a child's eligibility for Early Intervention Services.

66. The policy Deductible, Copayment, Coinsurance limitations, or any other limitations will not be applied to this benefit,
BENEFITS FOR NEUROPSYCHOLOGICAL TESTING FOR CHILDREN WITH CANCER

Benefits will be paid the same as any other Sickness without prior authorization for each Dependent child diagnosed with cancer, for neuropsychological testing ordered by a licensed Physician, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.

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

BENEFITS FOR AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Sickness for physical therapy, speech therapy, and occupational therapy services for the treatment of Autism Spectrum Disorders, as set forth in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”.

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

BENEFITS FOR EPIDERMOLYSIS BULLOSA TREATMENT

Benefits will be paid for the Usual and Customary Charges for wound-care supplies that are Medically Necessary for the treatment of Epidermolysis Bullosa provided such benefits are administered under the direction of a Physician.

“Epidermolysis Bullosa” is a genetic disorder caused by a mutation in the keratin gene. The disorder is characterized by the presence of extremely fragile skin and recurrent blister formation, resulting from minor mechanical friction or trauma.

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

BENEFITS FOR HUMAN LEUKOCYTE ANTIGEN TESTING

Benefits will be paid the same as any other Sickness for expenses arising for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantations.

Such testing shall be performed in a facility a) accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and b) certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time.

Benefits are limited to Insured Persons who, at the time of such testing, complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy; however, any Deductible, Copayment, Coinsurance or other out of pocket expense shall not exceed 20% of the cost of the testing Per Policy Year.

BENEFITS FOR BLOOD LEAD SCREENING

Benefits will be paid for the Usual and Customary Charges for blood lead screening and risk assessment ordered by an Insured’s primary Physician.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.
67. PART IX
EXCLUSIONS AND LIMITATIONS

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

1. Acne;
2. Acupuncture;
3. Allergy including allergy testing;
4. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the Benefits for Early Intervention Services;
5. Biofeedback;
6. Congenital conditions, except as specifically provided for Newborn or adopted Infants;
7. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
8. 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;
9. Dental treatment, except as specifically provided in the Policy;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
13. Flat foot conditions; supportive devices for the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
14. Health spa or similar facilities; strengthening programs;
15. Hearing examinations; hearing aids, except as specifically provided in the Benefits for Hearing Aids for Children; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

16. Hirsutism; alopecia;

17. Hypnosis;

18. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;

19. For Accidental Death and Dismemberment Benefit only, no indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his Physician for the Insured;

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

21. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency when traveling for academic study abroad programs, business or pleasure;

22. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;

23. Injury sustained while (a) participating in any intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

24. Investigational services;

25. Lipectomy;

26. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation;

27. Participation in a riot, civil disorder or a felony, except when Injury occurs when the Insured Person has an elevated blood alcohol content or when under the influence of intoxicating liquor or any drug or both. Participation means to voluntarily take a part or share with others assembled together in some activity. Riot means a violent public disturbance of the peace by a number of persons assembled together;
28. Pre-existing Conditions for a period of 12 months, except for congenital anomalies of a Newborn Infant; or, except for individuals who have been continuously insured under the student insurance policy for at least 12 consecutive months. Credit will be given for Pre-existing Conditions for newly Insured Persons who were covered under previous Qualifying Coverage, but not covered for such Pre-existing Conditions under the Qualifying Coverage when (a) the preceding Qualifying Coverage was continuous to a date not less than 120 days prior to their effective date under this policy; and for (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy. This Pre-existing Condition Limitation will not apply to newly Insured Persons who were covered for such Pre-existing Conditions, under previous Qualifying Coverage when (a) the preceding Qualifying Coverage was continuous to a date not less than 120 days prior to their effective date under this policy; and for (b) newly Insured Persons who apply within 30 days of initial eligibility under this policy and whose previous Qualifying Coverage was terminated due to the involuntary loss of employment and was continuous to a date not more than 150 days prior to their effective date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;

29. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy:
   a) Therapeutic devices or appliances, including: hypodermic needles, and syringes, except for hypodermic needles or syringes prescribed by a Physician for the purpose of administering medications for medical conditions, provided such medications are covered under the policy, support garments and other non-medical substances, except as specifically provided in the policy;
   b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
   c) Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The U.S. Pharmacopeia Drug Information Guide for the Health Care Professional (USP DI); (2) The American Medical Association’s Drug Evaluations (AMA DE); or (3) The American Society of Hospital Pharmacist’s American Hospital Formulary Service Drug Information (AHFS-DI);
   d) Products used for cosmetic purposes;
   e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
   f) Anorectics - drugs used for the purpose of weight control;
   g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra; except as specifically provided in the Benefits for Infertility Treatment;
   h) Growth hormones; or
   i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

30. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except as specifically provided in the Benefits for Infertility Treatment; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

31. 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 for a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the Sickness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a Phase III clinical trial of the Federal Food and Drug Administration; or except as specifically provided in the policy;

32. Routine Newborn Infant Care, well-baby nursery and related Physician charges, except as specifically provided in the policy;

33. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
34. Services provided without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee for which the Insured is not charged;

35. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except as specifically provided in the Benefits for Treatment of Craniofacial Disorders; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;

36. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

37. Sleep disorders;

38. Speech therapy; naturopathic services;

39. Injury resulting from suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

40. Supplies, except as specifically provided in the policy;

41. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Benefits for Reconstructive Breast Surgery and Benefits for Treatment of Tumors and Leukemia;

42. Treatment in a Government hospital for which the Insured is not charged, unless there is a legal obligation for the Insured Person to pay for such treatment;

43. 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); and

44. Weight management, weight reduction, nutrition programs, treatment for obesity, and surgery for removal of excess skin or fat.
POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

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

<table>
<thead>
<tr>
<th>Loss</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$5,000</td>
</tr>
<tr>
<td>Two or More Members</td>
<td>$5,000</td>
</tr>
<tr>
<td>One Member</td>
<td>$2,500</td>
</tr>
<tr>
<td>Thumb or Index Finger</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

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

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

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

PRE-ADMISSION NOTIFICATION

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

1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS: The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

2. NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS: The patient, patient’s representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

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

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

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

130. In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Network Pharmacy Prescription Drug Benefits

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

131.

132. Copayment and/or Coinsurance Amount

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

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

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

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

133.

134. Supply Limits

135.

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Schedule of Benefits. For a single Copayment and/or Coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

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

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

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling Customer Service at 1-877-417-7345.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change, and therefore the Copayment and/or Coinsurance may change. The Insured will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug is assigned.
Notification Requirements

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

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

Prescription Drugs Products which require notification are:

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.uhsr.com or by calling Customer Service at 1-877-417-7345.

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

When the Insured submits a claim on this basis, the Insured may pay more because they did not notify the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, Ancillary Charge and any Deductible that applies.

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

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person’s selection of Network Pharmacies may be limited. If this happens, the Company may require the Insured to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the designated single Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will select a single Network Pharmacy for the Insured.

Coverage Policies and Guidelines

The Company’s Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on its behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product’s acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

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

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

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access www.uhcsr.com through the Internet or call Customer Service 1-877-417-7345 for the most up-to-date tier status.

Rebates and Other Payments

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

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

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

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

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

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

If the Insured has a life-threatening Injury or Sickness (one which is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

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

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Unproven Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured’s Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

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

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

Prescription Drug Cost means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company’s periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service 1-877-417-7345.

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

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days’ supply or quantity limit) which exceeds the supply limit.

2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3).

4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent unless a Medical Necessity. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.
RESOLUTION OF GRIEVANCE NOTICE
INTERNAL APPEAL PROCESS AND EXTERNAL INDEPENDENT REVIEW PROCESS
RELATED TO HEALTH CARE SERVICES

DEFINITIONS

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

**Adverse Determination** means the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under the Company’s health benefit plan requested by an Insured Person or an Insured Person's Physician, based on a determination by the Company or its designee utilization review company:

1. That, based upon the information provided, (I) upon application of any utilization review technique, such benefit does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or (II) is determined to be experimental or investigational;

2. Of an Insured Person’s eligibility to participate in the Company’s health benefit plan; or

3. Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under the Company’s health benefit plan requested by an Insured Person or an Insured Person’s Physician.

Adverse determination includes a recission of coverage determination for grievance purposes.

**Authorized Representative** means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person;

2. A person authorized by law to provide substituted consent for an Insured Person;

3. An Insured Person’s family member or health care provider when the Insured Person is unable to provide consent;

4. A health care professional when the Insured Person’s health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

5. In the case of an urgent care request, a health care professional with knowledge of the Insured Person’s medical condition.

**Concurrent Review** means utilization review conducted during an Insured Person’s stay or course of treatment in a facility, the office of a Physician or other inpatient or outpatient health care setting, including home care.

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

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

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

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

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

1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or

2. In the opinion of a physician with knowledge of the Insured Person’s medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
**Utilization Review** means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of, health care services, procedures, or health care settings. Such techniques may include the monitoring of or evaluation of (1) health care services performed or provided in an outpatient setting, (2) the formal process for determining, prior to discharge from a facility, the coordination and management of the care that an Insured Person receives following discharge from a facility, (3) opportunities or requirements to obtain a clinical evaluation by a Physician other than the one originally making a recommendation for a proposed health care service, (4) coordinated sets of activities conducted for individual patient management of serious, complicated, protracted or other health conditions, or (5) prospective review, concurrent review, retrospective review or certification.

**INTERNAL APPEAL PROCESS**

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

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

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

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

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

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

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

The company shall issue a Final Adverse Decision in writing or electronically to the Insured Person or the Authorized Representative as follows:

1. For a Prospective Review, the notice shall be made no later than 30 days after the Company’s receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 60 days after the Company’s receipt of the grievance.

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

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

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

**Expedited Internal Review (EIR) of an Adverse Determination**

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

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

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

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

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

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

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.

**EXTERNAL INDEPENDENT REVIEW**

An Insured Person or Authorized Representative may submit a request for an External Independent Review when the service in question:
1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level of care, effectiveness, or the treatment is determined to be experimental or investigational.

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 120 days to request an External Independent Review. All requests for an External Independent Review shall be made in writing to the Commissioner and shall be accompanied by a $25.00 filing fee, except that no Insured Person or Authorized Representative shall pay more than $75.00 in a Policy Year. If the Commissioner finds that the Insured Person is indigent or unable to pay the filing fee, the Commissioner shall waive such fee. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

I. Standard External Review (SER) Process

1. Within 5 business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
   a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. the Insured Person has exhausted the Company’s Internal Appeal Process;
   c. the Insured Person has provided all the information and forms necessary to process the request; and
   d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

2. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
   a. If the request is not complete, the Company’s response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Company’s response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.

3. After receiving notice that a request is eligible for SER, the Commissioner shall, within 1 business day:
   a. Assign an Independent Review Organization (IRO) from the Commissioner’s approved list; and
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

4. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company’s failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.

5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.

6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.

b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.

c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.

7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

II. Expedited External Review (EER) Process

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Commissioner at the time the Insured Person receives:

a. An Adverse Determination if:
   (i) the Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
   (ii) the Adverse Determination involves a medical condition for which the timeframe for completing an EIR would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or

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

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

2. Upon receipt of a request for an EER, the Commissioner shall immediately review the request to determine that:

a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;

b. the Insured Person has exhausted the Company’s Internal Appeal Process, unless the Insured Person is not required to do so as specified in sections II. 1. a. and b. shown above;

c. the Insured Person has provided all the information and forms necessary to process the request; and

d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

3. Immediately after completion of the review, the Company shall notify the Commissioner, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.

a. If the request is not complete, the Company’s response shall include what information or materials are needed to make the request complete;

b. If the request is not eligible, the Company’s response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner

4. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an IRO from the Commissioner’s approved list and notify the Company of the name of the assigned IRO.

a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.

b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.

5. a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.

b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person’s grievance remains unresolved at the end of the EIR process.

6. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.

7. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

III. Standard Experimental or Investigational Treatment External Review (SEIER) Process

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Commissioner.

2. Within 5 business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
   a. the individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
   b. the recommended or requested health care services or treatment:
      i. is a Covered Medical Expense under the Insured Person’s Policy except for the Company’s determination that the service or treatment is experimental or investigational for a particular medical condition; and
      ii. is not explicitly listed as an Exclusion or Limitation under the Insured Person’s Policy;
   c. the Insured Person’s treating Physician has certified that one of the following situations is applicable:
      i. standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      ii. standard health care services or treatments are not medically appropriate for the Insured Person;
      iii. there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. the Insured Person’s treating Physician:
      i. has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician’s opinion, than any available standard health care services or treatments; or
      ii. who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person’s condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
   e. the Insured Person has exhausted the Company’s Internal Appeal Process; and
   f. the Insured Person has provided all the information and forms necessary to process the request.

3. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
   a. If the request is not complete, the Company’s response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.

4. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within 1 business day:
   a. Assign an IRO from the Commissioner’s approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

5. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company’s failure to provide the documents and information will not delay the SEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.

7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
   b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
   c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.

8. After completion of the IRO’s review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

IV. Expedited Experimental or Investigational Treatment External Review (EEIER) Process

1. An Insured Person or an Authorized Representative may make an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the Commissioner at the time the Insured Person receives:
   a. An Adverse Determination if:
      (i) The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      (ii) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person’s treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or
   b. A Final Adverse Determination, if:
      (i) The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
      (ii) The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person’s treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

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

2. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:
   a. the individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
   b. the recommended or requested health care services or treatment:
      (i) is a Covered Medical Expense under the Insured Person’s Policy except for the Company’s determination that the service or treatment is experimental or investigational for a particular medical condition; and
      (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person’s Policy;
   c. the Insured Person’s treating Physician has certified that one of the following situations is applicable:
      (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
      (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. the Insured Person’s treating Physician:
      (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician’s opinion, than any available standard health care services or treatments; or
      (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person’s condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
   e. the Insured Person has exhausted the Company’s Internal Appeal Process unless the Insured person is not required to do so as specified in Section IV. 1. a. and b. above; and
   f. the Insured Person has provided all the information and forms necessary to process the request.
3. The Company shall immediately notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
   a. If the request is not complete, the Company’s response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Company’s response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. After receiving notice that a request is eligible for EEIER, the Commissioner shall immediately:
   a. Assign an IRO from the Commissioner’s approved list; and
   b. Notify the Company of the name of the assigned IRO.
5. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6. a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
   b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person’s grievance remains unresolved at the end of the EIR process.
7. a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company’s failure to provide the documents and information will not delay the EEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
8. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
9. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
   b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
   c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
10. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 5 calendar days after being selected by the IRO.
11. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
12. Upon receipt of the IRO’s notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

**BINDING EXTERNAL REVIEW**

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

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service or Infirmary for treatment or referral, 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, social security number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.

3) File claim within 30 days of Injury or first onset of Sickness. should must be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by:
UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:
UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700
customerservice@uhcsr.com
claims@uhcsr.com

Sales/Marketing Services:
UnitedHealthcare Student Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
727-563-3400
1-800-237-0903
E-Mail: info@uhcsr.com

Please keep this Brochure 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 Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy # 2012-201337-1 v1