HPHC INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

NON-RENEWABLE ONE YEAR TERM INSURANCE

Designed Especially for the Students of

Coverage underwritten by HPHC Insurance Company, Inc., an affiliate of Harvard Pilgrim Health Care, Inc.,
And administered by UnitedHealthcare Student Resources

2024-2025

THIS PLAN DOES NOT INCLUDE ANY EXCLUSIONS OR LIMITATIONS FOR PRE-EXISITING CONDITIONS.

This health plan meets the Minimum Creditable Coverage standards that are effective January 1, 2024 as part of the Massachusetts Health Care Reform Law. This plan will satisfy the statutory requirement that the Insured Person must have health insurance meeting these standards.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website www.mahealthconnector.org.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2024. BECAUSE THESE STANDARDS MAY CHANGE, THE INSURED PERSON SHOULD REVIEW THE INSURANCE PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER THE PLAN MEETS THE LATEST STANDARDS.

The Insured may contact the Division of Insurance with any questions by calling (617) 521-7794 or by visiting the Division's website at www.mass.gov/doi.

This Certificate of Coverage is Part of Policy # 2024-209-1

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

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

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

Harvard Pilgrim Health Care

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Introduction

Welcome to the Harvard Pilgrim Student Health Insurance Plan. Your Plan is underwritten by HPHC Insurance Company, an affiliate of Harvard Pilgrim Health Care. The Plan is administered by UnitedHealthcare Student Resources, one of the leading providers of student health insurance to colleges and universities.

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

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-800-977-4698. You can also write to the Company at:

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

Section 1: Who Is Covered

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

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

All registered full-time and part-time students are automatically enrolled in this insurance plan, this includes students enrolled in a full-time internship approved by WPI, unless proof of comparable coverage is furnished.

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

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

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

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

Dependent eligibility expires concurrently with that of the Named Insured.

Medicare Eligibility

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

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

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

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2024. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 11, 2025. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.
There is no pro-rata or reduced premium payment for late enrollees. Refunds of premiums are allowed only upon entry into the armed forces.

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

Continuation of Coverage upon Divorce or Separation: A Dependent spouse may elect to continue coverage under this policy in the event that the spouse's coverage terminates due to divorce or legal separation from the Named Insured, unless the judgment of divorce or separation provides otherwise. Coverage will, in no event, continue beyond the earliest of one of the following:

1. The remarriage of either the Named Insured or the former Dependent spouse. However, upon remarriage of the Named Insured, if provided in the judgment of divorce, the former Dependent spouse may elect to continue coverage at additional premium rates, as determined by the Company.
2. The date that the Named Insured's coverage terminates.
3. The period of time set forth in the judgment of divorce or separation.
4. The last day for which the Company has received the required premium.
5. The date the policy terminates.

Section 3: Voluntary and Involuntary Disenrollment Rate

The voluntary and involuntary disenrollment rate (as defined under 211 CMR 52.13) for Insureds in Massachusetts for HPHC Insurance Company for 2023 was 0%.

Section 4: Physician Information

Physician profiling information, so-called, may be available from the Board of Registration in Medicine for Physician's licensed to practice in Massachusetts.

Section 5: Consumer Information

An Insured Person may contact the Company to obtain information regarding benefits, Copayments, Deductibles, Coinsurance, or other out-of-pocket expenses related to a proposed admission, procedure, or service that is covered under the Policy. An Insured may also request an estimated amount the Insured would be responsible for paying for an admission, procedure, or service, based on the information available to the Company at the time the request is made. An Insured may also request an estimated or maximum allowed amount or charge for a proposed admission, procedure, or service.

The information provided will be an estimate. Actual amounts may vary based on unforeseen services and expenses that arise out of any proposed admission, procedure, or service.

To obtain information, the Insured may contact the Company at:

Toll-Free Telephone
1-800-977-4698
Real Time Information available Monday through Friday – 7:00am to 7:00 pm Central Time

Online at:
www.uhcsr.com/wpi
Real Time Information available Monday through Friday – 7:00am to 7:00 pm Central Time

Section 6: Complaint Resolution

Insured Persons, Preferred Providers, Out-of-Network Providers or their representatives with questions or complaints may call the Customer Service Department at 1-800-977-4698. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

Section 7: Extension of Benefits after Termination

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

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

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

Section 8: Pre-Admission Notification

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

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

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

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

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

Section 9: Benefits Payable

All benefits are payable without discrimination for all Insured Persons under this plan. Benefits currently mandated by state and federal law are contained within these benefit provisions.

Section 10: Preferred Provider and Out-of-Network Provider Information

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

"Preferred Providers" are the Physicians, Hospitals and other health care providers who participate in the HPHC Insurance Company Network.

Preferred Provider Hospitals include HPHC Insurance Company Network.

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

The Insured may also call the Customer Service Department at 1-800-977-4698 for assistance in finding a Preferred Provider.

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

A provider's status may change. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling Customer Service at 1-800-977-4698 and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com/wpi.

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

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-800-977-4698 to find out if they are eligible for continuity of care benefits.

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

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

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

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

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

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

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

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

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

Continuity of Care: Termination of Provider Contracts

In the event that a health care provider is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud:

1. Any Insured Person in the second or third trimester of pregnancy may continue treatment with said provider, consistent with the terms of the policy, for the period up to and including the Insured’s first post-partum visit.
2. Any Insured Person who is terminally ill may continue treatment with said provider, consistent with the terms of the policy, until the Insured’s death.

In addition, the Company will provide benefits for up to 30 days from the effective date of coverage to a new Insured Person by a Physician who is not a Participating Provider if:

1. The Policyholder only offers the Insured a choice of carriers in which said Physician is not a Participating Provider.
2. The Physician is providing the Insured with an ongoing course of treatment.
3. With respect to an Insured Person in the second or third trimester of pregnancy, benefits shall be provided up to and including the Insured’s first post-partum visit.
4. With respect to an Insured Person who is terminally ill, benefits shall be provided up to the Insured’s date of death.

Section 11: Medical Expense Benefits

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

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

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

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

Inpatient

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

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

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

   Benefits will be paid for services and supplies such as:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Supplies.

4. **Routine Newborn Care.**
See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care.

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

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

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

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

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

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

10. **Pre-admission Testing.**
Benefits are limited to routine tests such as:
- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:
- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

11. **Surgery.**
Physician's fees for outpatient surgery.

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

13. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with outpatient surgery.

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

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

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

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

See also Benefits for Cardiac Rehabilitation, Benefits for Home Health Care Services, Benefits for Treatment of Autism Spectrum Disorders, and Benefits for Treatment of Speech, Hearing and Language Disorders.

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

17. **Medical Emergency Expenses.**
Only in connection with a Medical Emergency as defined. Benefits will be paid for:
- Facility charge for use of the emergency room and supplies.
- Attending Physician's charges.
- X-rays.
- Laboratory procedures.
- Tests and procedures.
- Injections.

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

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

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

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

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

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

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

23. **Chemotherapy.**
See Schedule of Benefits.

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

Other

25. **Ambulance Services.**
Benefits are payable for Medical Emergency only. See Schedule of Benefits.

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

For the purposes of this benefit, the following are considered durable medical equipment.
- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.
- Prosthetic devices as provided for in Benefits for Prosthetic Devices and Repair.
- Augmentative communication devices that assist in restoring speech when an Insured is unable to communicate due to an Injury or Sickness.
- Oxygen, oxygen concentrators, and the equipment to administer it for use in the home.

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

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

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician for Injury to Sound, Natural Teeth.

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

Benefits will also be paid the same as any other Injury or Sickness for:
- Reduction of a dislocation or fracture of the jaw or facial bone.
- Excision of a benign or malignant tumor of the jaw.
- Orthognathic surgery needed to correct a significant functional impairment that cannot be adequately corrected with orthodontic services.
- Removal of fully or partially impacted teeth.
- Facility charges for a serious medical condition (such as hemophilia or heart disease) that requires an Inpatient Hospital or day surgery facility admission in order for the dental care to be safely performed.

Benefits do not include orthognathic surgery performed mainly for cosmetic purposes.

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

29. **Mental Illness Treatment.**
See Benefits for Treatment of Mental Disorders.

30. **Substance Use Disorder Treatment.**
See Benefits for Treatment of Mental Disorders.

31. **Maternity.**
Same as any other Sickness for maternity-related services, including prenatal and postnatal care.

See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care.

32. **Complications of Pregnancy.**
Same as any other Sickness. See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care.

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Benefits include all 18 FDA-approved contraceptive drugs and devices and office visits associated with contraceptive management. Please see https://www.hrsa.gov/womensguidelines for a list of contraceptives. Benefits for hormonal contraceptives will be covered for up to a 12-month supply when dispensed or furnished at one time for an Insured Person by a provider or pharmacy at a location licensed or otherwise authorized to dispense drugs or supplies. Contraceptive coverage may be excluded for certain exempt religious groups.

Benefits also include tobacco use screening and counseling for all adult tobacco users, including cessation interventions such as nicotine gum, patches, lozenges, inhalers, oral or nasal sprays, or Bupropion and Varenicline when obtained with a prescription.

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

See also Benefits for Cytologic Screening and Mammographic Examinations, Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care, and Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services, and Benefits for Dependent Children Preventive Care.

34. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Initial Prosthetic Device and Reconstructive Surgery Incident to Mastectomy.

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

36. **High Cost Procedures.**
The following procedures provided on an outpatient basis:

- CT Scan.
- PET Scan.
- Magnetic Resonance Imaging.

37. **Home Health Care.**
See Benefits for Home Health Care Services.

38. **Hospice Care.**
See Benefits for Hospice Care.

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

40. **Skilled Nursing Facility.**
Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:
- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

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

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

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

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

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

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

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

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:
- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

See also Benefits for Qualified Clinical Trials for Treatment of Cancer.

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

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

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

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

45. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the attached Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits endorsements.

46. **Allergy Treatment.**
Benefits for allergy testing and treatment are provided at the benefit levels specified in the Schedule of Benefits based on the type of covered service performed.

Benefits include:
- Allergy testing (such as PRIST, RAST, and scratch tests).
- Allergy injections.
- Allergy serum extracts.

47. **Chiropractor Services.**
Same as any other Sickness for chiropractor services, including, but not limited to:
- Diagnostic lab tests (such as blood tests).
- Diagnostic X-rays other than magnetic resonance imaging.
- Computerized axial tomography (CT) scans.
- Other Medically Necessary imaging tests.
- Outpatient medical services (such as spinal manipulation).

48. **Dialysis Services.**
Benefits for dialysis services include outpatient dialysis when it is furnished by:
- A Hospital.
- A community health center.
- A free-standing dialysis facility.
- A Physician.

Benefits also include home dialysis when administered at the direction of a Physician. Home dialysis includes:
- Non-durable medical supplies (such as dialysis membrane and solution, tubing, and drugs needed during the dialysis.
- Installation of the dialysis equipment in the Insured's home.
- Maintenance or repair costs for the dialysis equipment.

Home dialysis benefits are not provided for costs:
- To obtain or supply power, water, or waste disposal systems.
- To hire a person to help with the dialysis procedure.
- Not needed to run the dialysis equipment.

49. **Family Planning.**
Benefits for family planning services are provided for the following:
- Consultations, exams, procedures, and medical services related to the use of all contraceptive methods to prevent pregnancy that have been approved by the U.S. Food and Drug Administration (FDA).
- Injection of birth control drugs. This includes a Prescription Drug when it is supplied during the office visit.
- Insertion of levonorgestrel implant system, including the implant system itself.
- IUDs, diaphragms, and other prescription contraceptive methods approved by the FDA, when the items are supplied during the office visit.
- Genetic counseling.

Benefits are not provided for:
- Services related to achieving pregnancy through a surrogate (gestational carrier).
- Non-prescription birth control preparations, such as condoms, birth control foams, jellies, and sponges.

Family planning services covered by the Preventive Care Services benefit shall be provided as specified under Preventive Care Services and shall not be subject to the Deductible, Copays, or Coinsurance when performed by a Preferred Provider. This includes voluntary sterilization for a female Insured when performed primarily for family planning reasons.

50. **Fitness Benefit.**
Benefits are limited to reimbursement for three consecutive months for one family health club membership. Alternatively, benefits may be provided for reimbursement of up to 10 fitness classes taken by the Insured or by any combination of the Insured and the Insured's Dependent(s) per Policy Year.

Benefits are limited to fees paid to:
- Privately owned or privately sponsored health clubs or fitness facilities.
- YMCA's or YWCA's.
- Jewish community centers.
- Municipal fitness centers.

Benefits are not provided for fees or costs paid for:
- Personal training.
- Country clubs.
- Social clubs.
- Sports teams or leagues.
- Spas.
- Instructional dance studios.
- Martial arts schools.

51. **Ostomy Supplies.**
Benefits for ostomy supplies are limited to the following supplies:
- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.
- Urinary catheters.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

52. **Podiatry Care.**
Same as any other Sickness for Medically Necessary podiatry care, including but not limited to treatment for hammertoe and osteoarthritis.

Benefits also include:
- Diagnostic lab tests.
- Diagnostic x-rays.
- Surgery and necessary post-operative care.

53. **Routine Hearing Exam.**
Same as any other Sickness for one routine hearing exam per Insured Person, per Policy Year.

54. **Temporomandibular Joint Disorder.**
Benefits for the diagnosis and treatment of temporomandibular joint (TMJ) disorder, limited to the following:
- Diagnostic X-rays.
- Surgical repair or intervention.
- Non-dental services to diagnose and treat a TMJ disorder.
- Splint therapy, including measuring, fabricating, and adjusting the splint.
- Physical therapy.

Benefits do not include:
- Services or supplies for TMJ disorders that are not caused by or result in a specific medical condition.
- Appliances, other than a mandibular orthopedic repositioning appliance (MORA).
- Services, supplies, or procedures to change the height of teeth or restore occlusion (such as bridges, crowns, or braces).

55. **Weight Loss Programs.**
Same as any other Sickness for Hospital-based medical weight loss programs.

Benefits do not include coverage for commercial weight loss programs such as: Jenny Craig, LA Weight Loss, Weight Watchers, or fasting programs.

Section 12: Mandated Benefits

BENEFITS FOR CARDIAC REHABILITATION

Benefits will be paid the same as any other Sickness for Cardiac Rehabilitation. Cardiac Rehabilitation shall mean multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a Hospital or other setting and which shall meet standards promulgated by the commissioner of public health. Benefits shall include, but not be limited to, outpatient treatment which is to be initiated within twenty-six (26) weeks after diagnosis of such disease.

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

BENEFITS FOR CYTOLOGIC SCREENING AND MAMMOGRAPHIC EXAMINATIONS

Benefits will be paid the same as any other Sickness for:

1. An annual cytologic screening for women eighteen (18) years of age or older.
2. A baseline mammogram for women between the ages thirty-five (35) and forty (40).
3. An annual mammogram for women forty (40) years of age and older.

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

All other Cytologic Screening and Mammographic Examinations benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR INFERTILITY TREATMENT

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Infertility for Insured Persons residing within the Commonwealth of Massachusetts to the same extent that benefits are provided for other pregnancy-related procedures. Benefits will include, but not be limited to, the following Non-experimental Infertility Procedures:
1. Artificial Insemination (AI) and Intrauterine Insemination (IUI).
2. In Vitro Fertilization and Embryo Transfer (IVF-ET).
3. Gamete Intra-Fallopian Transfer (GIFT).
4. Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
5. Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility.
6. Zygote Intrafallopian Transfer (ZIFT).
7. Assisted Hatching.
8. Cryopreservation of eggs.

Benefits are not provided for the following Experimental Infertility Procedures:

1. Any Experimental Infertility Procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner.
2. Surrogacy.
3. Reversal of Voluntary Sterilization.

"Infertility" means:

1. For females 35 and younger shall mean the inability to conceive or produce conception during a period of one year.
2. For females over the age of 35 shall mean the inability to conceive or produce conception during a period of six months.

For the purposes of meeting the criteria for infertility, if a person conceived but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included on the calculation of the one year or six month period as applicable.

"Non-experimental Infertility Procedures" means a procedure which is: 1) recognized as such by the American Society for Reproductive Medicine (ASRM) or the American College of Obstetrics and Gynecology (ACOG) or the Society of Assisted Reproductive Technology (SART) or another infertility expert recognized as such by the Commission; and 2) incorporated as such in this provision by the Commissioner after a public hearing pursuant to M.G.L. c. 30A.

"Experimental Infertility Procedures" means a procedure not yet recognized as non-experimental, as defined above.

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

BENEFITS FOR MATERNITY, CHILDBIRTH, WELL-BABY AND POST-PARTUM CARE

Benefits will be paid the same as any other Sickness for the expense of prenatal care, childbirth classes, childbirth and post-partum care. Benefits will be provided for a minimum of forty-eight hours of in-patient care following a vaginal delivery and a minimum of ninety-six hours of in-patient care following a caesarean section for a mother and her newly born child including routine well-baby care. Any decision to shorten such minimum stay shall be made by the attending Physician in consultation with the mother. Any such decision shall be made in accordance with rules and regulations promulgated by the Department of Public Health. Said regulations shall be relative to early discharge, defined as less than forty-eight hours for a vaginal delivery and ninety-six hours for a caesarean delivery. Post-delivery care shall include, but not be limited to, home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit shall be conducted by a Physician. Additional Medically Necessary home visits shall be provided upon recommendation by a Physician.

Benefits will be paid the same as any other Sickness for Medically Necessary special medical formulas which are approved by the commissioner of the Department of Public Health, when prescribed by a Physician to protect the unborn fetuses of pregnant women with phenylketonuria.

Lactation services for prenatal and postnatal lactation support, counseling, and equipment purchase and/or rental covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Lactation services for prenatal and postnatal lactation support, counseling, and equipment purchase and/or rental received from an Out-of-Network Provider shall be paid at the Preferred Provider cost-sharing amount if no Preferred Provider is available within the network. Benefits for lactation services without cost-sharing shall extend for the duration of the breastfeeding period.

Maternity, Childbirth, Well-Baby and Post-Partum Care services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

All other Maternity, Childbirth, Well-Baby and Post-Partum Care benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR ABORTION AND ABORTION-RELATED CARE

Benefits will be paid the same as any other Sickness for Abortion or Abortion-Related Services.

"Abortion" means any medical treatment intended to induce the termination of, or to terminate, a clinically diagnosable pregnancy except for the purpose of producing a live birth. Abortion shall not include care related to a miscarriage.

"Abortion-Related Services," when provide in conjunction with a payable abortion procedure, means;

1. Pre-operative evaluation and examination.
2. Pre-operative counseling.
3. Laboratory services, including pregnancy testing, blood type, and Rh factor.
4. Rho (D) immune globulin (human).
5. Anesthesia (general or local).
6. Post-operative care.
7. Follow-up care.
8. Advice on contraception or referral to family planning services.

Benefits will also include ultrasounds, pre-abortion evaluation and examination, and post-abortion care provided in conjunction with a covered surgical or medication-based abortion.

Abortion or Abortion-related care shall not be subject to any Deductible, Copayment, Coinsurance, or any other cost-sharing requirement provisions of the Policy.

BENEFITS FOR ENTERAL FORMULA

Benefits will be paid the same as any other Sickness for nonprescription enteral formulas for home use when a Physician has issued a written order for such formula and when Medically Necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Benefits for inherited diseases of amino acids and organic acids shall include food products modified to be low protein. Benefits are provided for formulas that are taken orally as well as those that are administered by tube.

Benefits shall be subject to a copayment for a 30-day supply of enteral formula that is equal to the copayment required for outpatient Physician Visits.

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

BENEFITS FOR BONE MARROW TRANSPLANTS FOR TREATMENT OF BREAST CANCER

Benefits will be paid the same as any other Sickness for a bone marrow transplant or transplants for Insureds who have been diagnosed with breast cancer that has progressed to metastatic disease. Insureds must meet the criteria established by the Department of Public Health and which are consistent with medical research protocols reviewed and approved by the National Cancer Institute.

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

BENEFITS FOR HUMAN LEUKOCYTE ANTIGEN OR HISTOCOMPATIBILITY LOCUS ANTIGEN TESTING

Benefits will be paid the same as any other Sickness for human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability for potential donors for Insured Persons. Benefits shall include the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.

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

BENEFITS FOR INITIAL PROSTHETIC DEVICE AND RECONSTRUCTIVE SURGERY INCIDENT TO MASTECTOMY

Benefits will be paid the same as any other Sickness for a Mastectomy and the initial prosthetic device or reconstructive surgery incident to the Mastectomy. Benefits shall be provided for 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. When a Mastectomy is performed and there is no evidence of malignancy, benefits will be limited to the cost of the prosthesis or reconstructive surgery to within two years after the date of the Mastectomy.

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

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

BENEFITS FOR SCALP HAIR PROSTHESES

Benefits will be paid for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia when a written statement by a Physician is furnished stating that the scalp hair prosthesis is Medically Necessary.

Benefits shall include coverage when hair loss is due to chemotherapy, radiation therapy, infections, burns, traumatic Injury, congenital baldness, and Sicknesses resulting in alopecia areata or alopecia totalis (capitus).

Benefits do not include any scalp hair prostheses worn for male pattern baldness, female pattern baldness, natural aging, or premature aging.

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

BENEFITS FOR HOSPICE CARE

When an Insured Person is diagnosed with a covered Injury or Sickness, and therapeutic intervention directed toward the cure of the Injury or Sickness is no longer appropriate, and the Insured's medical prognosis is one in which there is a life expectancy of six months or less as a direct result of such Injury or Sickness, benefits will be payable for the Covered Medical Expenses incurred as specified in the Schedule of Benefits for services and supplies for hospice care prescribed by a Physician and provided by a licensed hospice agency, organization or unit. This benefit does not cover non-terminally ill patients who may be confined in: a convalescent home, rest or nursing facility; a skilled nursing facility; a rehabilitation unit or a facility that provides treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts, or alcoholics. For this benefit to be payable, a written statement from the attending Physician that the Insured is terminally ill within the terms of this benefit and a written statement from the hospice certifying the days on which services were provided must be furnished to the Company.

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

BENEFITS FOR HOME HEALTH CARE SERVICES

Benefits will be paid for the Covered Medical Expenses incurred as specified in the Schedule of Benefits for Home Health Care Services. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such services are determined to be a Medically Necessary component of said nursing and physical therapy. Benefits for Home Health Care Services are payable only when such services are Medically Necessary and provided in conjunction with a Physician approved Home Health Care Services plan. Durable medical equipment and supplies provided as part of an approved Home Health Care Services plan will not be subject to any policy limitations regarding durable medical equipment and supplies.

"Home health care services" means health care services for an Insured Person by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Said services shall include, but not be limited to, nursing and physical therapy.

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

BENEFITS FOR TREATMENT OF DIABETES

Benefits will be paid the same as any other Sickness for Medically Necessary services and supplies for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes when prescribed by a Physician.

Benefits will be paid for the following, subject to any applicable Deductibles, Copayments and Coinsurance as set forth on the Schedule of Benefits:

1. **Prescription Drugs:** blood glucose monitoring strips for home use; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; insulin pumps and insulin pump supplies; insulin pens and prescribed oral diabetes medications that influence blood sugar levels.

2. **Durable medical equipment:** blood glucose monitors; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind.
3. **Laboratory/radiological services:** including glycosylated hemoglobin, or HbAlc tests; urinary protein/microalbumin and lipid profiles.
4. **Prosthetics:** therapeutic/molded shoes and shoe inserts prescribed by a Physician and approved by the Federal Drug Administration for the purposes for which they were prescribed for Insureds who have severe diabetic foot disease.
5. **Outpatient services:** diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a Physician certified in diabetes health care.

As used in this section, a "Physician certified in diabetes health care" means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

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

BENEFITS FOR TREATMENT OF SPEECH, HEARING, AND LANGUAGE DISORDERS

Benefits will be paid the same as any other Injury or Sickness for Medically Necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists. Benefits will be paid for services provided in a Hospital, clinic or private office. Benefits will not be provided for the diagnosis or treatment of speech, hearing and language disorders for services provided in a school-based setting.

Benefits include coverage for the full cost of hearing aids for Insured Persons who are 21 years of age or younger, limited to one hearing aid per hearing impaired ear, up to $2,000 for each hearing aid every 36 months. Benefits are limited to hearing aids that are determined to be Medically Necessary by the Insured's Physician. Benefits shall include all related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting, adjustments, and supplies, including ear molds.

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

BENEFITS FOR OFF-LABEL DRUG USE FOR CANCER OR HIV/AIDS

Benefits will be paid the same as any other Prescription Drug for any drug prescribed to treat an Insured Person for cancer or HIV/AIDS if the drug is recognized treatment for that indication in one of the Standard Reference Compendia, in Medical Literature, or in the Association of Community Cancer Centers' Compendia-Based Drug Bulletin.

"Standard reference compendia" means (a) the United States Pharmacopeia Drug Information; (b) the American Medical Association Drug Evaluations; or (c) the American Hospital Formulary Service Drug Information.

"Medical literature" means scientific studies published in any peer-reviewed national professional journal.

For such Prescription Drugs that are payable due to establishment by the commissioner as payable after a review of the panel of medical experts as outlined in Massachusetts Insurance Code, 175:47L, benefits will be paid for such drugs that are not included in any of the standard reference compendia or in the medical literature for the treatment of cancer.

Benefits shall include Medically Necessary services associated with the administration of such drugs.

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

BENEFITS FOR TREATMENT OF MENTAL DISORDERS

Benefits will be paid for the treatment of mental disorders as specified in the Policy Schedule of Benefits for Mental Illness Treatment and Substance Use Disorder Treatment. Benefits will be provided as set forth below.

Benefits will be provided for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to in this benefit as the "DSM":

1. Schizophrenia.
2. Schizoaffective disorder.
3. Major depressive disorder.
4. Bipolar disorder.

5. Paranoia and other psychotic disorders.
6. Obsessive-compulsive disorder.
7. Panic disorder.
8. Delirium and dementia.
9. Affective disorders.
10. Eating disorders.
11. Post traumatic stress disorder.
12. Substance Use Disorders.
13. Autism.

Benefits will be provided for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of chapter 258C.

Benefits will be provided for an Insured Person under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child/adolescent provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by a Physician, or is evidenced by conduct, including, but not limited to:

1. An inability to attend school as a result of such disorder.
2. The need to hospitalize such Insured Person as a result of such disorder.
3. A pattern of conduct or behavior caused by such disorder which poses a serious danger to self or others.

Such benefits to an Insured Person who is engaged in an ongoing course of treatment shall continue beyond the Insured Person's nineteenth birthday until said course of treatment, as specified in such Insured Person's treatment plan, is completed and while the policy under which such benefits first became available remains in effect, or subject to a subsequent policy which is in effect.

Benefits will be provided for the diagnosis and treatment of all other mental disorders not otherwise provided for in this benefit section and which are described in the most recent edition of DSM.

Treatment shall be provided in the least restrictive clinically appropriate setting and shall include the following services:
1. Medically Necessary inpatient, intermediate, and outpatient services that are expected to lead to improvement of the condition in a reasonable period of time.
2. Medically Necessary noncustodial treatment for the Mental Disorder.

Benefits may be provided to the child/adolescent, the child/adolescent's parent(s), or other appropriate caregiver. Educational services to improve academic performance or developmental functioning are not covered.

Inpatient services may be provided in a general Hospital licensed to provide such services, in a facility under the direction and supervision of the Department of Mental Health, in a private mental Hospital licensed by the Department of Mental Health, or in a Substance Use Disorder facility licensed by the Department of Public Health.

Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Public Health or the Department of Mental Health. Intermediate services for children and adolescents shall include the following:
1. Community-based acute treatment (CBAT): intensive therapeutic services provided in a staff-secure setting on a 24-hour basis, with sufficient staffing to ensure safety, while providing intensive therapeutic services including but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; specializing (as needed); individual group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services or stepdown services for children and adolescents that is usually provided as an alternative to mental health acute treatment.
2. Intensive community-based acute treatment (ICBAT): provides the same services as CBAT but at a higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community

as an alternate to inpatient hospitalization. ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

3. Mobile crisis intervention: short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, seven days a week to a child experiencing a behavioral health crisis to identify, assess, treat and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.

Outpatient services may be provided in a licensed Hospital, a mental health or Substance Use Disorder clinic licensed by the Department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a Licensed Mental Health Professional acting within the scope of his license. Outpatient services for children and adolescents shall include the following:

1. Intensive care coordination (ICC): a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service is delivered in office, home or other settings and shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate.
2. In-home behavioral services (IHBS): a combination of behavior management therapy and behavior management monitoring. Services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. In-home behavioral services include:
    a. Behavior management monitoring of a child's behavior, the implementations of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other care giver.
    b. Behavioral management therapy that addresses challenging behaviors that interfere with a child's successful functioning. That therapy shall include a functional behavioral assessment and observation of the youth in the home and/or community setting, development of a behavior plan, and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy and may include short-term counseling and assistance.
3. In-home therapy (IHT): therapeutic clinical intervention or ongoing therapeutic training and support. The intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.
    a. Therapeutic clinical intervention shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) the use of established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.
    b. Ongoing therapeutic training and support of a treatment plan pursuant to therapeutic clinical intervention that includes but is not limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situation and assisting the family in supporting the child and addressing the child's emotional and mental health needs.
4. Family support and training (FS&T): services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs. Such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups.
5. Therapeutic mentoring (TM) services: services provided to a child designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis. Services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Services shall be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral treatment plan. It may also be delivered in the community to allow the youth to practice desired skills in appropriate settings.

Benefits include psychopharmacological services and neuropsychological assessment services.

When necessary for administration of claims under this benefit section, consent to the disclosure of information regarding services for mental disorders will be required on the same basis as disclosure of information for other Sickness or Injury.

Benefits will not be payable for mental health benefits or services: which are provided to a person who is incarcerated, confined or committed to a jail, house of correction or prison, or custodial facility in the department of youth services within the commonwealth or one of its political subdivisions; which constitute educational services required to be provided by a school committee pursuant to section 5 of chapter 71B; or which constitute services provided by the Department of Mental Health.

"Licensed mental health professional" means:

1. A Physician who specializes in the practice of psychiatry.
2. A licensed psychologist.
3. A licensed independent clinical social worker.
4. A licensed mental health counselor.
5. A licensed nurse mental health clinical specialist.
6. A certified addictions Registered Nurse.
7. A licensed alcohol and drug counselor 1.
8. A clinician practicing under the supervision of a licensed professional and working toward licensure in a clinic.
9. A healthcare provider qualified within the scope of his or her license to perform Substance Use Disorder evaluations, including interns, residents, or fellows pursuant to medical staff policies and practice.

If a mental health provider rendering intermediate care or outpatient services to treat child/adolescent mental health disorders is not independently licensed at the Masters/PhD/MD level, then the supervisor, who must be a Masters Level independently licensed mental health professional, must sign off on the treatment plan whenever the child's or adolescent's condition changes.

Benefits also include Mental Illness and Substance Use Disorder services delivered through a Psychiatric Collaborative Care Model.

"Psychiatric collaborative care model" means the evidence -based, integrated behavioral health service delivery method in which a primary care team consisting of a primary care provider and care manager provides structured care management to a patient, and that works in collaboration with a psychiatric consultant that provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.
Benefits for Medically Necessary Emergency Service Programs will be provided on a nondiscriminatory basis.

"Emergency service programs" are programs subject to contract between the Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of community-based emergency psychiatric services, including, but not limited to, behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through:

1. Mobile crisis intervention services for youth.
2. Mobile crisis intervention services for adults.
3. Emergency service provider community-based locations.
4. Adult community crisis stabilization services.

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

BENEFITS FOR MENTAL HEALTH WELLNESS EXAMINATION

Benefits will be provided for an annual Mental Health Wellness Examination performed by a Licensed Mental Health Professional or Primary Care Provider, which may be provided by the Primary Care Provider as part of an annual preventive visit.

For the purpose of this benefit, "Licensed mental health professional" means:

1. A licensed Physician who specializes in the practice of psychiatry.
2. A licensed psychologist.
3. A licensed independent clinical social worker.
4. A licensed certified social worker.
5. A licensed mental health counselor.
6. A licensed supervised mental health counselor.
7. A licensed psychiatric nurse mental health clinical specialist.
8. A licensed psychiatric mental health nurse practitioner.

9. A licensed physician assistant who practices in the area of psychiatry.
10. A licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J.
11. A licensed marriage and family therapist within the lawful scope of practice for such therapist.

"Mental health wellness examination" means a screening or assessment that seeks to identify any behavioral or mental health needs and appropriate resources for treatment. The examination may include:

1. Observation, a behavioral health screening, education and consultation on healthy lifestyle changes, referrals to ongoing treatment, mental health services and other necessary supports and discussion of potential options for medication.
2. Age-appropriate screenings or observations to understand the Insured's mental health history, personal history and mental or cognitive state and, when appropriate, relevant adult input through screenings, interviews and questions.

"Primary care provider" means a health care professional qualified to provide general medical care for common health care problems, who:

1. Supervises, coordinates, prescribes or otherwise provides or proposes Covered Medical Expenses.
2. Initiates referrals for specialist care.
3. Maintains continuity of care within the scope of practice.

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

BENEFITS FOR TREATMENT OF AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Mental Illness for the Diagnosis and Treatment of Autism Spectrum Disorders.

"Autism Services Provider" means a person, entity, or group that provides treatment of Autism Spectrum Disorders.

"Autism Spectrum Disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

"Board Certified Behavior Analyst" means a behavior analyst credentialed by the behavior analyst certification board as a board certified behavior analyst.

"Diagnosis of Autism Spectrum Disorders" means Medically Necessary assessments, evaluations including neuropsychological evaluations, genetic testing, or other tests to diagnose whether an individual has one of the Autism Spectrum Disorders.

"Treatment of Autism Spectrum Disorders" includes the following types of care which are prescribed, provided, or ordered for an individual diagnosed with one of the Autism Spectrum Disorders by a licensed Physician or licensed psychologist who determines that care to be Medically Necessary:

1. Habilitative or rehabilitative care, including professional, counseling and guidance services and treatment programs, including but limited to, Applied Behavior Analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functions of an individual.
2. Pharmacy care, including medications prescribed by a licensed Physician and health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
3. Psychiatric care, which includes direct or consultative services provided by a licensed psychiatrist.
4. Psychological care, which includes direct or consultative services provided by a licensed psychologist.
5. Therapeutic care, including services provided by licensed or certified speech therapists, occupational therapists, physical therapists, or social workers.

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

Benefits shall not be subject to a limit on the number of visits an Insured Person may make to an autism services provider. Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR TREATMENT OF CLEFT LIP AND CLEFT PALATE

Benefits will be paid the same as any other Sickness for the cost of treating cleft lip and cleft palate for an Insured Person under the age of 18.

Benefits shall include:

1. Medical, dental, oral, and facial surgery.
2. Surgical management and follow-up care by oral and plastic surgeons.
3. Orthodontic treatment and management.
4. Preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment.
5. Prosthetic management therapy, speech therapy, audiology, and nutrition services, if such services are:
   a. Prescribed by the treating Physician.
   b. Certified by the treating Physician to be Medically Necessary.
   c. Consequent to the treatment of cleft lip or cleft palate.

Benefits provided under this section shall not include dental or orthodontic treatment not related to the management of cleft lip or cleft palate.

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

BENEFITS FOR QUALIFIED CLINICAL TRIALS FOR TREATMENT OF CANCER

Benefits will be paid the same as any other Sickness for Patient Care Service furnished pursuant to a Qualified Clinical Trial.

Patient Care Service means a health care item or service that is furnished to an individual enrolled in a Qualified Clinical Trial which is consistent with the Allowed Amount standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial.

Qualified clinical trial means a clinical trial that meets all the following conditions:

1. The clinical trial is to treat cancer.
2. The clinical trial has been peer reviewed and approved by one of the following;
   a. United States National Institutes of Health.
   b. A cooperative group or center of the National Institutes of Health.
   c. A qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants.
   d. The United States Food and Drug Administration pursuant to an investigational new drug exemption.
   e. The United States Departments of Defense or Veterans Affairs.
   f. With respect to Phase II, III and IV clinical trials only, a qualified institutional review board.
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience.
4. With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center.
5. The patient meets the patient selection criteria defined in the study protocol for participation in the clinical trial;
6. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
7. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
8. The clinical trial does not unjustifiably duplicate existing studies.
9. The clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

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

BENEFITS FOR PROSTHETIC DEVICES AND REPAIRS

Benefits will be paid for Medically Necessary Prosthetic Devices and repairs under the same terms and conditions that apply to other durable medical equipment.

"Prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or leg.

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

BENEFITS FOR HORMONE REPLACEMENT THERAPY AND OUTPATIENT CONTRACEPTIVE SERVICES

Benefits will be paid the same as any other Sickness for outpatient hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services. Outpatient contraceptive services include consultations, examinations, procedures and medical services for all United States Food and Drug Administration (FDA) approved contraceptive methods to prevent pregnancy.

Benefits will be paid the same as any other Sickness for FDA approved hormone replacement therapy and outpatient prescription contraceptive drugs or devices.

Hormone Replacement Therapy and Outpatient Contraceptive Services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

All other Hormone Replacement Therapy and Outpatient Contraceptive Services benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR HYPODERMIC SYRINGES OR NEEDLES

Benefits will be paid for the Covered Medical Expenses incurred for Medically Necessary hypodermic syringes and needles.

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

BENEFITS FOR CHRISTIAN SCIENCE SERVICES

Benefits will be paid for services delivered in accordance with the healing practices of Christian Science. The cost sharing applicable to Room and Board and Hospital Miscellaneous Expenses or, if combined, Hospital Expense, stated in the Schedule of Benefits will apply to services in a Christian Science sanatorium.

All Deductibles, Copayments, Coinsurance, limitations or any other provisions of the Policy shall also apply to the services of Christian Science sanatoria. Religious aspects of care are not covered under this benefit.

BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

Benefits will be provided for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

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

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

BENEFITS FOR PRESCRIPTION EYE DROPS

Benefits will be paid the same as any other Prescription Drug for Covered Medical Expenses incurred for refills of prescription eye drops in accordance with the Guidance for Early Refill Edits of Topical Ophthalmic Products provided that:

1. The prescribing Physician indicates on the original prescription that additional quantities of the prescription eye drops are needed.
2. The requested refill does not exceed the number of additional quantities indicated on the original prescription.

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

BENEFITS FOR HIV-ASSOCIATED LIPODYSTROPHY SYNDROME TREATMENT

Benefits will be paid the same as any other Sickness for medical or drug treatments to corrector or repair disturbances of body composition caused by HIV-associated lipodystrophy syndrome.

Benefits shall include, but are not limited to, the following:

1. Reconstructive surgery, such as suction assisted lipectomy.
2. Other restorative procedures.
3. Dermal injections or fillers for reversal of facial lipoatrophy syndrome.

Coverage requires a statement from the treating Physician that the services are necessary for correcting, repairing, or ameliorating the effects of HIV-associated lipodystrophy syndrome.

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

BENEFITS FOR LYME DISEASE THERAPY

Benefits will be paid the same as any other Prescription Drug for long-term antibiotic therapy for the treatment of Lyme disease.

Benefits shall be provided when the long-term antibiotic therapy is determined to be Medically Necessary and ordered by the Insured's Physician after making a thorough evaluation of the Insured's symptoms, diagnostic test results, or response to treatment. An experimental drug shall be covered as long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration; provided, however that a drug, including an experimental drug, shall be covered for an off-label use in the treatment of Lyme disease if the drug has been approved by the United State Food and Drug Administration.

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

BENEFITS FOR NEWBORN OR ADOPTED CHILDREN

Benefits will be paid for Newborn Infants, including Newborn Infants of a Dependent, from the moment of birth the same as any other Insured Dependent. Benefits shall also be provided for Adopted or Adoptive Children of the Insured Person immediately from the date of the filing of a petition to adopt under chapter two hundred and ten and thereafter if the child has been residing in the home of the Insured Person as a foster child for whom the Insured Person has been receiving foster care payments, or, in all other cases, immediately from the date of placement by a licensed placement agency of the child for purposes of adoption in the home of the Insured Person. Benefits for Newborn Infants and Adoptive Children shall include treatment of Injury and Sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth.

Benefits shall include those special medical formulas which are approved by the commissioner of the Department of Public Health, prescribed by a Physician, and are Medically Necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or Medically Necessary to protect the unborn fetus of a pregnant woman with phenylketonuria.

Benefits shall include screening for lead poisoning on the basis required by the Department of Public Health.

Benefit shall include a newborn hearing screening test to be performed before the Newborn Infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the Department of Public Health.

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

BENEFITS FOR DEPENDENT CHILDREN PREVENTIVE CARE

Benefits will be paid for the Allowed Amount for those preventive and primary services delivered or supervised by a Physician that are rendered to a Dependent child of an Insured from the date of birth through the attainment of six years of age. Benefits include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Benefits shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician.

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

All other Dependent Children Preventive Care benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the Policy.

BENEFITS FOR DEPENDENT CHILDREN EARLY INTERVENTION SERVICES

Benefits will be paid the same as any other Sickness for early intervention services for Dependent children from birth to their third birthday. Certified early intervention specialists in accordance with an early intervention program approved by the Department of Public Health and in accordance with applicable certification requirements shall provide early intervention services.

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

BENEFITS FOR PAIN MANAGEMENT ALTERNATIVES TO OPIATE PRODUCTS

Benefits will be paid the same as any other Sickness for pain management methods other than opiate treatment that are Medically Necessary to manage pain linked to a physical cause.

Benefits include at least:

1. Two (2) alternative Prescription Drug medication treatment options.
2. Three (3) non-medication treatment modalities such as services or treatments that are appropriate as ordered by or provided by a Physician for pain management on an outpatient basis. Examples of non-medication treatment modalities include: manipulative treatment, non-manipulative osteopathic care, physical therapy and occupational therapy.

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

BENEFITS FOR PEDIATRIC AUTOIMMUNE NEUROPSYCHIATRIC DISORDERS ASSOCIATED WITH STREPTOCOCCAL INFECTION AND PEDIATRIC ACUTE-ONSET NEUROPSYCHIATRIC SYNDROME

Benefits will be paid the same as any other Sickness for the treatment of PANDAS and PANS, including but not limited to, the use of intravenous immunoglobulin therapy.

“Pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS)", means a condition in which streptococcal infection in a child or adolescent causes a subset of symptoms within the broader PANS classification.

“Pediatric acute-onset neuropsychiatric syndrome (PANS)” means a condition characterized by the sudden onset of obsessive-compulsive symptoms or eating restrictions, accompanied by two (2) or more symptoms of acute behavioral deterioration or motor and sensory changes, or both.

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

BENEFITS FOR COVID-19 TESTING AND SERVICES

Benefits will be provided for Medically Necessary treatment related to emergency, Inpatient, and cognitive rehabilitation services, including all professional, diagnostic, and laboratory services related to the 2019 novel coronavirus, also known as COVID-19, whether provided by a Preferred Provider or an Out-of-Network Provider.

Benefits also include Medically Necessary outpatient testing, including testing for asymptomatic Insureds under circumstances defined by the Massachusetts Secretary of Health and Human Services.

No cost sharing applies to services provided by either a Preferred Provider or an Out-of-Network Provider.

Section 13: Coordination of Benefits Provision

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

Definitions

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

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

   Allowable Expenses shall not be interpreted to require a Plan that makes its provider payments on the basis of capitation or other similar alternative reimbursement methodology to make any reimbursements beyond the negotiated capitation or other payment arrangement between the provider and carrier.

2. **Health Benefit Plan.** A policy, contract, certificate or agreement that reimburses any costs of health care services. Medical Payments Coverage and Personal Injury Protection shall not be considered a Health Benefit Plan.

3. **Medical Payments Coverage.** Medical coverage that may be purchased by an Insured Person in conjunction with the purchase of a Massachusetts motor vehicle insurance policy.

4. **Personal Injury Protection (PIP).** Coverage included in a Massachusetts motor vehicle liability policy.

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

   Plan includes all of the following:
   - Group and nongroup insurance contracts and subscriber contracts.
   - Uninsured arrangements of group or group-type coverage.
   - Group and nongroup coverage through closed panel Plans.
   - Group-type contracts, including blanket contracts.
   - The medical care components of long-term care contracts, such as skilled nursing care.
   - The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
   - Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of Plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

- Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.
- Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of vision care.

Plan does not include any of the following:
- Hospital indemnity coverage benefits or other fixed indemnity coverage.
- Accident only coverage.
- Limited benefit health coverage as defined by state law.
- Specified disease or specified accident coverage.
- Insurance Contracts that pay fixed daily benefit without regard to which expenses are incurred or services received.
- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
- Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
- Medicare supplement policies.
- State Plans under Medicaid.
- A governmental Plan, which, by law, provides benefits that are in excess of those of any private insurance Plan or other nongovernmental Plan.

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

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

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

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

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

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

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

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

If the Primary Plan is not a closed panel Plan and the Secondary Plan is a closed panel Plan, and the Insured Person uses a provider that is not within the Secondary Plan's provider network, then the Secondary Plan is not required to pay or provide benefits, except for Emergency Services or authorized referrals that are paid or provided by the Primary Plan.

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

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

1. **Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies.** If an Insured Person has both a Health Benefit Plan and a motor vehicle insurance policy and that Insured Person incurs expenses as a result of a motor vehicle accident, the PIP coverage shall always be primary for the first $2,000 of expenses. The PIP shall thereafter be secondary to and shall coordinate with the Health Benefit Plan.

   Medical payment Coverage under a motor vehicle insurance policy shall always be secondary to and in excess of any Health Benefit Plan or Personal Injury Protection.

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

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

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

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

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

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

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

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

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

7. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

- First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.
- Second, the benefits under the COBRA or continuation coverage.
- If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

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

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

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

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

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

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

Section 14: Definitions

ADOPTED OR ADOPTIVE CHILD means:

1. A child from the date of the filing of a petition to adopt who has been residing in the home of the Insured as a foster child and the Insured has been receiving foster care payments, provided the person adopting the child is insured under the policy on the date the petition is filed; or
2. A child from the date of placement by a licensed placement agency for purposes of adoption in the home of the Insured provided the person adopting the child is insured under this policy on the date the child is placed with the Insured.

Such child will be covered under the policy for the first 31 days after:

1. The date of the filing of a petition to adopt a foster child; or
2. The date of placement of a child for purposes of adoption.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, a) apply to the Company, and b) pay the required additional premium (if any) for the continued coverage within 31 days after:

1. The Filing of a petition to adopt; or
2. The date of placement for purposes of adoption.

If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the date of:

1. Filing of a petition to adopt; or
2. Placement of a child for purposes of adoption.

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

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

Allowed amounts are based on the following:

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

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

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

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

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

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

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

1. Negotiated rates agreed to by the Out-of-Network Provider and either the Company or one of Our vendors, affiliates or subcontractors.
2. If rates have not been negotiated, then one of the following amounts:
   - Allowed amounts are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographical market, with the exception of the following.

- 50% of CMS for the same or similar freestanding laboratory service.
- 45% of CMS for the same or similar Durable Medical Equipment from a freestanding supplier, or CMS competitive bid rates.
- 70% of CMS for the same or similar physical therapy service from a freestanding provider.

- When a rate for all other services is not published by CMS for the service, the allowed amount is based on 20% of the provider's billed charge.

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

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

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

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

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

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

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

Dependent shall also include any Newborn Infant of a dependent child of the Named Insured.

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).

DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who:

1. Is the Named Insured's sole spousal equivalent.
2. Lives together with the Named Insured in the same residence and intends to do so indefinitely.
3. Is responsible with the Named Insured for each other's welfare.

A domestic partner relationship may be demonstrated by any three of the following types of documentation:

1. A joint mortgage or lease.
2. Designation of the domestic partner as beneficiary for life insurance.
3. Designation of the domestic partner as primary beneficiary in the Named Insured's will.
4. Domestic partnership agreement.
5. Powers of attorney for property and/or health care.
6. Joint ownership of either a motor vehicle, checking account or credit account.

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 OR INVESTIGATIVE TREATMENT means a service, supply, procedure, device or medication that meets any of the following:

1. A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished.
2. A treatment, or the "informed consent" form used with a treatment, that was reviewed and approved by the treating facility's institutional review board or other body servicing a similar function, or federal law requires such review or approval.
3. Reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis.
4. Reliable evidence shows that prevailing opinion among experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence, as used in this definition, means only published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment; or the written informed consent form used by the treating facility or by another facility studying substantially the same treatment.

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

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.

2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)*).

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

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

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

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

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

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

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

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

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

INJURY means bodily injury which is all of the following:

1. Directly and independently caused by specific accidental contact with another body or object.
2. Unrelated to any pathological, functional, or structural disorder.
3. A source of loss.
4. Treated by a Physician within 30 days after the date of accident.
5. Sustained while the Insured Person is covered under the Policy.

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

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

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

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

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

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

MEDICAL EMERGENCY means a medical condition, whether physical, behavioral, related to Substance Use Disorder, or Mental Illness, manifesting itself by symptoms of sufficient severity, including severe pain that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in one of the following:

1. Placing the health of the Insured Person or another person in serious jeopardy.
2. Serious impairment to body functions or serious dysfunction of any body organ or part.
3. With respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

Expenses incurred for Medical Emergency will be paid only for Sickness or Injury which fulfills the above conditions.

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

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

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

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

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

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

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

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

NEWBORN INFANT means any child born of an Insured Person while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed Congenital Conditions, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

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

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. This includes but is not limited to certified registered nurse anesthetists, nurse practitioners, physician assistants, certified nurse midwives, podiatrists, chiropractors, optometrists or any other legally licensed practitioner of the healing arts who is practicing within the scope of his/her license. Physicians eligible for reimbursement under the terms of the Policy shall include pediatric specialty care Physicians, including mental health care, by Physicians with recognized expertise in specialty pediatrics to eligible Insureds requiring such services.

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

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

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

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

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

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

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

PRESCRIPTION DRUGS means any of the following:

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.
4. Injectable insulin.

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

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

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

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

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

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

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

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

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

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

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

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders are considered one Sickness.

TELEHEALTH/TELEMEDICINE means the use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology, including, but not limited to:

1. Interactive audio-video technology.
2. Remote patient monitoring devices.
3. Audio-only telephone.
4. Online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of an Insured's physical health, oral health, Mental Illness or Substance Use Disorder condition.

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

Section 15: 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. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
   - Improve or give back bodily function or to correct a functional impairment caused by a birth defect or a prior surgical procedure.
   - Medically Necessary reconstructive procedures that are for gender reaffirming or gender dysphoria treatment. This exclusion does not apply to Benefits for HIV-Associated Lipodystrophy Syndrome Treatment.
4. 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.
5. Dental treatment, except:
   - As described under Dental Treatment in the Policy.

   This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
6. Elective Surgery or Elective Treatment.
7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
8. Foot care for the following:
   - Flat foot conditions.
   - Supportive devices for the foot.
   - Subluxations of the foot.
   - Fallen arches.
   - Weak feet.
   - Chronic foot strain.
   - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   This exclusion does not apply to:
   - Preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
   - Benefits specifically provided in Podiatry Care.
   - Medically Necessary treatment of a covered Injury or Sickness, as determined by the treating Physician.
9. Health spa or similar facilities. Strengthening programs.
10. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
    This exclusion does not apply to:
    - Hearing defects or hearing loss as a result of a Congenital Condition, infection, or Injury.
    - Benefits specifically provided in Benefits for Treatment of Speech, Hearing and Language Disorders.
11. 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.
12. Injury sustained while:
    - Participating in any intercollegiate or professional sport, contest or competition.
    - Traveling to or from such sport, contest or competition as a participant.
    - Participating in any practice or conditioning program for such sport, contest or competition.
13. Investigational services.
14. Lipectomy.
15. Marital or family counseling, except when related to Mental Illness.
16. Nuclear, chemical or biological contamination, whether direct or indirect. “Contamination” means the contamination or poisoning of people by nuclear and/or chemical and/or biological substances which cause Sickness and/or death.
17. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.
18. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
    - Immunization agents, except as specifically provided in the Policy.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.

- Anorectics - drugs used for the purpose of weight control.
- Drugs used for the treatment of erectile dysfunction or sexual dysfunction.
- Growth hormones for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
- Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

19. Reproductive services for the following, except as specifically provided in Benefits for Infertility:
    - Genetic testing.
    - Reversal of sterilization procedures.
20. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
21. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.
    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To contact lenses to treat keratoconus.
    - To benefits specifically provided in the Policy.
22. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
23. Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planing. Bungee jumping.
24. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
25. Supplies, except as specifically provided in the Policy.
26. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except:
    - As specifically provided in the Policy.
    - Medically Necessary reconstructive procedures that are for gender affirming or gender dysphoria treatment.
27. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
28. 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).
29. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Weight Loss Programs or as specifically provided in the Policy.

Section 16: Medical Emergency Treatment

In the event of Injury or Sickness, the Insured should contact their Physician or report to the Student Health Service if such services are available to the Insured. Should the Insured have a condition that a prudent layperson would consider a Medical Emergency, the Insured should go to the nearest Physician or Hospital or call the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent. An Insured is not required to contact the Company prior to treatment. An Insured will not be denied coverage for medical and transportation expenses incurred as a result of a Medical Emergency involving a mental health condition.

After 72 hours of Inpatient care and if an Insured has been stabilized, the Company has the right to require an Insured to be transferred to a Preferred Provider Hospital in order to continue benefit levels at the Preferred Provider rate. Any such transfer must be approved by the attending Physician. If the Insured is not considered stabilized at that time, the Company has the right to require transfer to a Preferred Provider Hospital when the Insured is deemed stabilized by the attending Physician. If the Insured does not accept transfer, benefits will be payable at the Out-of-Network rate following the day in which such transfer was possible. See the Pre-Admission Notification Section for instructions on informing the Company of your expected Hospitalization or following emergency admission.

Section 17: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

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

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

Section 18: General Provisions

GRACE PERIOD: A grace period of 14 days will be provided for the payment of each premium payment due after the first premium. The Insured Person's premium must be received during the grace period to avoid a lapse in coverage, and the Insured Person must meet the eligibility requirements each time a premium payment is made.

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

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid within thirty (30) days upon receipt of due written proof of such loss. If payment is not made, the Company will notify the Insured or the Provider, as applicable, in writing specifying the reasons for the nonpayment or what additional documentation is necessary for payment of the claim. If the Company fails to comply with the prompt processing of claims requirements under applicable Massachusetts law, in addition to any benefits payable, interest on such benefits may accrue beginning forty-five (45) days after the Company's receipt of notice of claim at the rate of one and one-half (1 ½) percent per month, not to exceed eighteen (18) percent per year. The interest payments shall not apply to a claim which the Company is investigating because of suspected fraud.

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

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

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

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay

to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

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

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

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

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

Section 19: Notice of Appeal Rights

RESOLUTION OF GRIEVANCES

Internal Inquiry Process

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

If the Insured has a complaint about a claim denial, the Insured may call our Member Services telephone number 1-800-767-0700 for further explanation to informally resolve the complaint or contact the consumer assistance toll-free number maintained by the Office of Patient Protection at 1-800-436-7757. If the Insured is not satisfied with our explanation of why the claim was denied, the Insured, the Insured's authorized representative, or the Insured's provider may request an internal review of the claim denial.

The following is the Company's internal inquiry process:

1. The Insured must request in writing a benefit review within 60 days after receipt of the claim notice. This will be an informal reconsideration review process of the claim by a Claims Supervisor. The Insured may not attend this review.
2. A decision will be made by the Claims Supervisor, within three days after the receipt of the request for review or the date all information required from the Insured is received.
3. The Company will provide written notice to an Insured whose inquiry has not been explained or resolved to the Insured's satisfaction within three business days of the inquiry of the right to have the inquiry processed as an internal grievance under 958 CMR 3.300 through 958 CMR 3.313 at his/her option, including reduction of an oral inquiry to writing by the Company, written acknowledgment and written resolution of the grievance as set forth in 958 CMR 3.300 through 958 CMR 3.313. The Insured is not required to attend the grievance review.
4. The Company has a system for maintaining records for a period of two years of each inquiry communicated by an Insured or on his behalf and response thereto. These records shall be subject to inspection by the Commissioner of Insurance and the Office of Patient Protection.

Internal Grievance Review

1. The internal grievance material must be submitted in writing, by electronic means at SGrievances@uhcsr.com or by calling our Member Services telephone number 1-800-767-0700 by the Insured or the authorized representative for consideration by the grievance reviewer.
2. Within 15 business days after the Company receives the Insured's request for an internal grievance review, the Company must provide the Insured with a written acknowledgment of the receipt of the grievance, except where an oral grievance has been reduced to writing by the Company or this time period is waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company.

3. Any grievance that requires the review of medical records, shall include the signature of the Insured, or the Insured's authorized representative on a form provided promptly by the Company authorizing the release of medical and treatment information relevant to the grievance, in a manner consistent with state and federal law. The Insured and the authorized representative shall have access to any medical information and records relevant to the grievance relating to the Insured which is in the possession of and under the control of the Company. The Company shall request said authorization from the Insured when necessary for requests reduced to writing by the Company and for any written requests lacking said authorization. The Company shall establish a process to deliver and accept the medical release form to the Insured or the Insured's authorized representative by electronic means, which shall include, but not be limited to, delivery to a designated email address or in an online consumer portal.
4. The Insured may or may not attend this review but is not required to do so.
5. An internal grievance review written decision will be issued to the Insured and, if applicable, the Insured's provider, within 30 business days of the receipt of the grievance and shall be sent to the Insured by certified or registered mail or other express carrier with proof of delivery. When a grievance requires the review of medical records, the 30 business day period will not begin to run until the Insured or the Insured's authorized representative submits a signed authorization for release of medical records and treatment information as required in958 CMR 3.302 (2). In the event that the signed authorization is not provided by the Insured or the Insured's authorized representative, if any, within 30 business days of the receipt of the grievance, the Company may, in its discretion, issue a resolution of the grievance without review of some or all of the medical records. The 30 business day time period for written resolution of a grievance that does not require the review of medical records, begins on the day immediately following the three business day time period for processing inquiries pursuant to 958 CMR 3.300, if the inquiry has not been addressed within that period of time; or on the day the Insured or the Insured's authorized representative, if any, notifies the Company that s/he is not satisfied with the response to any inquiry under 958 CMR 3.300 if earlier than the three business day time period. The time limits in 958 CMR 3.305 may be waived or extended by mutual written agreement of the Insured or the Insured's authorized representative and the Company. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be an actively practicing Physician in the same or similar specialty who typically treat the medical condition, perform or provide the treatment that is the subject of the grievance to evaluate the matter. The written decision issued in a grievance review shall contain:

    a. The professional qualifications and licensure of the person or persons reviewing the grievance.
    b. A statement of the reviewer's understanding of the grievance.
    c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Company's position. In the case of a grievance that involves an adverse determination, the written resolution shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall at a minimum:
        1) identify the specific information upon which the adverse determination was based;
        2) discuss the Insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;
        3) specify alternative treatment options covered by the Company, if any;
        4) reference and include applicable clinical practice guidelines and review criteria; and
        5) notify the Insured or the Insured's authorized representative of the procedures for requesting external review.
    d. A reference to the evidence or documentation used as the basis for the decision.
    e. A statement advising the Insured of his or her right to request a reconsideration of the grievance decision and a description of the procedure for submitting a request for a reconsideration of the grievance decision.
    f. With every final adverse determination, the Company shall include a copy of the form prescribed by the Department of Insurance for the request of an external review.

Grievance Decision Reconsideration

1. A grievance decision reconsideration is available to the Insured dissatisfied with the grievance review decision.
2. The Company may offer to the Insured or the Insured's authorized representative, if any, the opportunity for reconsideration of a final adverse determination where relevant medical information:
    a. was received too late to review within the 30 business day time limit; or
    b. was not received but is expected to become available within a reasonable time period following the written resolution.
3. When an Insured or the Insured's authorized representative, if any, chooses to request reconsideration, the Company must agree in writing to a new time period for review, but in no event greater than 30 business days from the agreement to reconsider the grievance. The time period for requesting external review shall begin to run on the date of the resolution of the reconsidered grievance.

Expedited Grievance Review

The Company shall provide for an expedited resolution concerning plan coverage or provision of immediate and urgently needed services, which shall include, but not be limited to:

1. A written resolution pursuant to 958 CMR 3.307 before an Insured's discharge from a hospital if the grievance is submitted by an Insured or the Insured's authorized representative while the Insured is an inpatient in a hospital.
2. When a grievance is submitted by an Insured with a terminal illness, or by the Insured's authorized representative on behalf of the Insured with a terminal illness, a resolution shall be provided to the Insured or Insured's authorized representative within five business days from the receipt of such grievance, except that grievances regarding urgently needed services for such insureds shall be resolved within 72 hours.
3. Provisions for the automatic reversal of decisions denying coverage for services or durable medical equipment, pending the outcome of the internal grievance process, within 48 hours (or earlier for durable medical equipment at the option of a Physician responsible for treatment or proposed treatment of the covered patient) of receipt of certification by said Physician that, in the Physician's opinion:
   a. the service or use of durable medical equipment at issue in grievance is Medically Necessary;
   b. a denial of coverage for such services or durable medical equipment would create a substantial risk of serious harm to the Insured; and
   c. such risk of serious harm is so immediate that the provision of such services of durable medical equipment should not await the outcome of the normal grievance process.
4. Provisions that require that, in the event a Physician exercises the option of automatic reversal earlier than 48 hours for durable medical equipment, the Physician must further certify as to the specific, immediate and severe harm that will result to the Insured absent action within the 48 hour time period.

Expedited Process

1. When an expedited grievance request is submitted by an Insured, or by the Insured's authorized representative on behalf of said Insured, a resolution shall be provided to the Insured or said authorized representative within five business days from the receipt of such grievance.
2. If the expedited review process affirms the denial of coverage or treatment, the Company shall provide notice to the Insured or the Insured's authorized representative, if any, within two business days of the decision, including by any electronic means consented to by the Insured. The notice shall include:
   a. a statement setting forth the specific medical and scientific reasons for denying coverage or treatment.
   b. a description of the Insured's rights to any further appeal.
   c. a description of alternative treatment, services or supplies covered or provided by the Company, if any.
3. If the expedited review process affirms the denial of coverage or treatment to an Insured, the Company shall allow the Insured or the Insured's authorized representative, if any, to request a conference.
   a. The conference shall be scheduled within ten days of receiving a request from an Insured; provided however that the conference shall be held within five business days of the request if the treating Physician determines, after consultation with the Company's medical consultant or his designee, and based on standard medical practice, that the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies covered by the Company, would be materially reduced if not provided at the earliest possible date.
   b. At the conference, the Company shall permit attendance of the Insured, the authorized representatives of the Insured, if any, or both.
   c. At the conference, the Insured and/or the Insured's authorized representative, if any, and a Company representative who has authority to determine the disposition of the grievance shall review the information provided to the Insured under 958 CMR 3.09(1)(b) and (c).
4. If the expedited review process set forth in 958 CMR 3.310 results in a final adverse determination, the written resolution will inform the Insured or the Insured's authorized representative of the opportunity to request an expedited external review pursuant to 958 CMR 3.401 and, if the review involves the termination of ongoing services, the opportunity to request continuation of services pursuant to 958 CMR 3.414.

Failure to Meet Time Limits

A grievance not properly acted on by the Company within the required time limits required by 958 CMR 3.300 through 958 CMR 3.310 shall be deemed resolved in favor of the Insured. Time limits include any extensions made by mutual written agreement of the Insured or the Insured's authorized representative, if any, and the Company.

In the event the Company fails to properly act on an adverse determination within the required time limits, the grievance is immediately eligible for external review. The external review shall be decided in favor of the Insured unless the Company

provides substantial evidence, such as proof of delivery, that the Company properly complied with the time limits required under this section.

Coverage or Treatment Pending Resolution of Internal Grievance

If a grievance is filed concerning the termination of ongoing coverage or treatment, the disputed coverage or treatment shall remain in effect at the Company's expense through completion of the internal grievance process regardless of the final internal grievance decision, provided that the grievance is filed on a timely basis, based on the course of treatment. For the purposes of 958 CMR 3.312, ongoing coverage or treatment includes only that medical care that, at the time it was initiated, was authorized by us, unless such care is provided pursuant to 958 CMR 3.309 (2) and does not include medical care that was terminated pursuant to a specific time or episode-related exclusion from the Insured's contract for benefits.

External Review

Any Insured or authorized representative of an Insured who is aggrieved by a final adverse determination issued by the Company may request an external review by filing a request in writing with the Office of Patient Protection within four months of the Insured's receipt of written notice of the final adverse determination, except that no final adverse determination is required when the Insured simultaneously requests an expedited internal review and expedited external review pursuant to 958 CMR 3.401(4), or where the Company has waived internal review pursuant to 958 CMR 3.300(3).

An Insured or Insured's authorized representative may file a request for external review for services of any monetary value. There is no minimum financial threshold for filing a request for external review.

If the external review involves the termination of ongoing services, the Insured may apply to the external review panel to seek the continuation of coverage for the disputed service during the period the expedited or non-expedited review is pending. When applying, the Insured and/or the Insured's authorized representative should include any evidence of a pattern of denials that have been overturned by prior internal or external review. Any such request must be made before the end of the second business day following receipt of the final adverse determination. The review panel may order the continuation of coverage or treatment where it determines that substantial harm to the Insured's health may result absent such continuation or for such other good cause, as the review panel shall determine; provided, however, that good cause shall include a pattern of denials that have been overturned by prior internal or external appeals. Any such continuation of coverage shall be at the Company's expense regardless of the final external review determination. The decision of the review panel shall be binding on the Insured and the Company.

The Department of Public Health, Office of Patient Protection, is available to assist consumers with insurance related problems and questions. An Insured seeking a review is responsible to pay a fee of $25.00 to the Office of Patient Protection which shall accompany the request for a review. The fee may be waived by the Office of Patient Protection if it determines that the payment of the fee would result in an extreme financial hardship to the Insured.

An Insured or the Insured's authorized representative, if any, may request to have his or her request for review processed as an expedited external review. Any request for an expedited external review shall contain a certification, in writing, from a Physician, that delay in the providing or continuation of health care services that are the subject of a final adverse determination, would pose a serious and immediate threat to the health of the Insured. Upon a finding that a serious and immediate threat to the Insured exists, the Office of Patient Protection shall qualify such request as eligible for an expedited external review.

Requests for review submitted by the Insured or the Insured's authorized representative shall:

1. be on a form prescribed by the Commission;
2. include the signature of the Insured or the Insured's authorized representative consenting to the release of medical information;
3. include a copy of the written final adverse determination issued by us; and,
4. include the $25.00 fee required pursuant to 958 CMR 3.402 unless waived by 958 CMR 3.402 (2).

You may inquire in writing or by telephone for information concerning an external review to:

The Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109
Toll-Free - 1-800-436-7757
FAX – 617-624-5046
www.mass.gov/hpc/opp/

The Company shall comply with the external review agency's decision, and if directed by the agency, The Company shall make payment, authorize services, or otherwise comply without delay.

UnitedHealthcare Insurance Company has a system for maintaining records of each grievance filed by an Insured or on his behalf, and response thereto, for a period of seven years, which records shall be subject to inspection by the Commissioner of Insurance and the Department.

UnitedHealthcare Insurance Company provides the following information to the Office of Patient Protection no later than April 1st of each year:

1. a list of sources of independently published information assessing Insured's satisfaction and evaluating the quality of health care services offered by the Company;
2. the percentage of Physicians who voluntarily and involuntarily terminated participation contracts with the Company during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary Physician disenrollment;
3. the percentage of premium revenue expended by the Company for health care services provided to Insureds for the most recent year for which information is available;
4. a report detailing, for the previous calendar year, the total number of:
   a. filed grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution;
   b. external appeals pursued after exhausting the internal grievance process and the resolution of all such external appeals.

The above information is available to the insured or prospective insured from the Office of Patient Protection.

Where to Send External Review Requests
All types of External Review requests shall be submitted to the state insurance department at the following address:

The Commonwealth of Massachusetts
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109
Toll-Free - 1-800-436-7757
FAX – 617-624-5046
www.mass.gov/hpc/opp/

Questions Regarding Appeal Rights
Contact Customer Service at 1-800-977-4698 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Health Care for All
30 Winter Street, Suite 1004
Boston, MA 02108
(800) 272-4232
www.massconsumerassistance.org

Section 20: Online Access to Account Information

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

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

My Account now includes a message center - a self-service tool that provides a quick and easy way to view any email notifications the Company may have sent. Notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Profile and making the change there.

Section 21: Request Paper Documents

At any time, the Insured may request paper copies of any plan documents, including evidences of coverage, any amendments thereto, and any other documents available online.

To request a printed copy, free of charge, the Insured should call us toll-free at 1-800-977-4698.

Section 22: ID Cards

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

Section 23: UHCSR Mobile App

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

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

Section 24: Managed Care Information Provisions

Provider Directories

Provider Directories for the HPHC Insurance Company Network may be obtained:

1. By calling 1-800-977-4698.
2. From the Student Health Center.
3. By logging on to the website at www.uhcsr.com/wpi for information.

Service Area Directories

All counties in Massachusetts are included in the HPHC Insurance Company Network.

Assistance Locating a Provider or Making an Appointment

When an Insured is unable to find the appropriate type of Network provider in the Network directory to treat the Insured's condition based on age or type of treatment and to assist with questions related to finding a Network provider, the Insured may call the Company for assistance.

In addition, when an Insured has not been able to locate an available Network provider within the Network directory for certain difficult to treat ages or behavioral health conditions, the Insured may call the Company for assistance in contacting a provider or for help scheduling an appointment.

For assistance locating a Network provider, the Insured may contact the Company toll free at 1-888-889-3473 from 5:00 am – 9:00 pm Central Time.

Continuity of Coverage

1. If an Insured female is in her second or third trimester of pregnancy and her Physician providing care for her pregnancy is involuntarily disenrolled (other than disenrollment for quality-related reasons or for fraud), the Insured female may continue treatment with such Physician, consistent with the terms of this Certificate, for the period up to and including the Insured's first post-partum visit.

2. If an Insured is terminally ill and their Physician providing care in connection with said illness is involuntarily disenrolled (other than disenrollment for quality related reasons or for fraud) the Insured may continue treatment with such Physician consistent with the terms of this Certificate, until the Insured's death.
3. If a newly enrolled Insured is in an ongoing course of treatment and the Insured's Physician is not a participating provider in the Preferred Provider Network, benefits will be provided for such course of treatment for up to 30 days from the Effective Date of coverage, consistent with the terms of this Certificate.

Such continuity of coverage will only apply if such Physician agrees to the following: (a) to accept reimbursement from the Company at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Insured in an amount that would exceed the cost sharing that could have been imposed if the Physician had not been disenrolled; (b) to adhere to the quality assurance standards of the Company or Network and to provide the Company with necessary medical information related to the care provided; and (c) to adhere to the Company's policies and procedures. This section does not require coverage of benefits that would not have been covered if the Physician involved had remained a Preferred Provider.

Section 25: Utilization Review Program

The Company's Utilization Review Program consists of retrospective review of claims to determine that services and supplies were Medically Necessary. The Company does not require its Insureds to participate in a utilization review program that includes pre-authorization or concurrent review.

Responsibility:

The Special Investigations Unit is responsible for coordinating the Company's Utilization Review Program.

The Company coordinates certain functions with UnitedHealthcare (UHC) Clinical Services, as described below, and relies on the experience and qualifications of such UHC Medical Claim Review (MCR) Medical Directors when making utilization review determinations.

UHC MCR Medical Directors conduct Medical Necessity reviews for the company. MCR Medical Directors are board-certified physicians who provide clinical review of post service claims. UHC also contracts with several independent External Review Organizations or individual clinicians to perform Medical Necessity reviews for the Company in the State of Massachusetts.

Review Process:

The following procedures have been established to implement the Utilization Review Program:

1. The Company relies on the experience and training of its Claims Examiners to identify claims for services that may not be Medically Necessary as defined by the plan. Claims for services that are identified by the Claims Examiner as potentially not being Medically Necessary are submitted to the Claims Supervisor for review.
2. If the Claims Supervisor determines that a claim may not be Medically Necessary, then the claim is referred to the Claims Special Investigations Unit for review. Otherwise, the claim is processed according to the terms of the plan.
3. If the Claims Special Investigations Unit Manager determines that a claim may not be Medically Necessary, then the claim is referred to UHC Clinical Services for medical review. Otherwise, the claim is processed according to the terms of the plan.
4. a. If the Medical Reviewer agrees with the determination that services were not Medically Necessary, then the claim is declined. The Medical Reviewer provides the Company with its determination, and the Company is responsible for sending out the adverse determination letter to the Insured and to the provider if applicable.
   b. If the Medical Reviewer disagrees with the determination that services were not Medically Necessary (and therefore is of the opinion that services were Medically Necessary), then the claim is processed according to the terms of the plan.

Appeals:

The Company is the first point of contact if the Insured/provider wishes to request an informal explanation or review of their claim determination or to request an internal or external grievance review of their claim determination. A medical reviewer will be made available by telephone to discuss with practitioners determinations made based upon medical appropriateness. In addition, the Company will ensure that all resolutions will involve appropriate medical professionals and be in accordance with appropriate medical criteria.

The Insured, or the provider on behalf of the Insured, may request an explanation/informal reconsideration through our Internal Inquiry Process. If the inquiry requires clinical review, or if they do not want to avail themselves of the Internal Inquiry Process, they may request an Internal Grievance Review. The Internal Grievance Review is a defined process which also allows for a Grievance Decision Reconsideration. If the Insured, or the provider on behalf of the Insured, is not satisfied with the resolution of the Internal Grievance Review, they may request an external Grievance Review.

Oversight:

Oversight of the entire Utilization Review process will be performed at least annually by the Quality Improvement and Management Committee. This committee will review /update/approve the Utilization Management Program, including all processes and procedures, as a fully integrated part of the Company's quality improvement program.

The Utilization Review Program will require substantial involvement of UHC Clinical Services Medical Claims Review Medical Directors. Determinations will be based on the medical reviewers' expert opinion, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice and published clinical criteria from sources recognized in the area of specialty. Those medical standards of practice and published clinical criteria must be used by the Medical Reviewer in making its determinations.

In addition, the Medical Reviewer will be required to comply with state insurance codes/regulations/statutes for the state that has authority for the case. We will require that the Medical Reviewer makes available, on request, the UM criteria utilized to participating practitioners. We will also require that we be provided a copy of any information provided to the participating practitioners so that we may ensure compliance with this requirement.

We will monitor reviews that Medical Reviewers complete and the outcomes (including any appeals actions) of those reviews. Summary reports will be reviewed by the Quality Improvement and Management Committee appointed by the Company to determine if any concerns exist concerning decisions made by the Medical Reviewers (for example, patterns of adverse determination reversed upon appeal). In addition, the medical standards of practice and published clinical criteria used by the Medical Reviewer in making its determinations will be reviewed by the Utilization Review Committee to review/compare the decisions made by the Medical Reviewer.

Clinical Guidelines:

The Company consults with UnitedHealthcare medical policy experts, appropriate providers, and other external experts, as needed, regarding the establishment of policies and procedures. The Company adheres to evidence-based clinical guidelines as determined by the UnitedHealthcare Medical Technology and Assessment Committee. The Company's clinical guidelines are available on the provider's internet site and upon request.

Section 26: Quality Assurance

HPHC Insurance Company maintains a Quality Assurance Program. The goal of the Quality Assurance Program is to ensure the provision of consistently excellent health care to Insured Persons, enabling them to maintain and improve their physical and behavioral health and well-being.

Examples of quality activated in place include a systematic review and re-review of the credential of Preferred Providers and contracted facilities, as well as the development and dissemination of clinical standards and guidelines in areas such as preventive care, diabetes, and asthma, medical records, appointment access, confidentiality, the appropriate use of drug therapies and new medical technologies, and the investigation and resolution of quality-of-care complaints registered by individuals.

Section 27: Payment of Claims Provision

Indemnities payable under the policy for any loss will be paid within thirty (30) days upon receipt of due written proof of such loss. If payment is not made, the Company will notify the Insured or Provider, as applicable, in writing specifying the reasons for the nonpayment or what additional documentation is necessary for payment of the claim. If the Company fails to comply with the prompt processing of claims requirements under applicable Massachusetts law, in addition to any benefits payable, interest on such benefits may accrue beginning forty-five (45) days after the Company's receipt of notice of claim at the rate of one and one-half (1 ½) percent per month, not to exceed eighteen (18) percent per year. The interest payments shall not apply to a claim which the Company is investigating because of suspected fraud.

Section 28: Important Company Contact Information

The Policy is Underwritten by:
HPHC INSURANCE COMPANY

Administrative Office:
HPHC Insurance Company
c/o UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-977-4698
Website: www.uhcsr.com/wpi

Sales/Marketing Services:
HPHC Insurance Company
c/o UnitedHealthcare Student Resources
11399 16th Court North, Suite 110
St. Petersburg, FL 33716
Email: info@uhcsr.com

Customer Service:
800-977-4698
(Customer Services Representatives are available Monday - Friday, 7:00 a.m. – 7:00 p.m. (Central Time))

Schedule of Benefits

Worcester Polytechnic Institute
2024-209-1
METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 90.440%
Injury and Sickness Benefits

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

Deductible	$0 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network Provider	60% except as noted below
Out-of-Pocket Maximum	$4,500 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum	$9,000 (For all Insureds in a Family, Per Policy Year)

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

The **Preferred Provider** for this plan is HPHC Insurance Company Network.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If a Preferred Provider is not available in the Network Area, benefits will be paid for Covered Medical Expenses provided by an Out-of-Network Provider at the Preferred Provider Benefit level. “Network Area” means the geographic service area approved by the Massachusetts Division of Insurance.

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

Covered Medical Expenses incurred at a Preferred Provider facility by an Out-of-Network Provider will be paid at the Preferred Provider level of benefits, unless the Insured had a reasonable opportunity to choose to have the service performed by a Preferred Provider.

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

Student Health Center Benefits:

- The Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center. Policy Exclusions and Limitations do not apply.
- Benefits will be paid at the Preferred Provider Benefit level when treatment is referred by the Student Health Center for the following services: Routine and Preventive Care laboratory services rendered at the SHC and referred to Quest Diagnostics for processing. Policy Exclusions and Limitations do not apply.

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

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	Allowed Amount	Allowed Amount
Intensive Care	Allowed Amount	Allowed Amount
Hospital Miscellaneous Expenses	Allowed Amount	Allowed Amount

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Routine Newborn Care See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount	Allowed Amount
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount	Allowed Amount
Anesthetist Services	Allowed Amount	Allowed Amount
Registered Nurse's Services	Allowed Amount	Allowed Amount
Physician's Visits	Allowed Amount	Allowed Amount
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount	Allowed Amount

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	100% of Allowed Amount	80% of Allowed Amount
Day Surgery Miscellaneous	Allowed Amount	Allowed Amount
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount	Allowed Amount
Anesthetist Services	Allowed Amount	Allowed Amount
Physician's Visits	$10 Copay per visit 100% of Allowed Amount	80% of Allowed Amount
Physiotherapy Limits per Policy Year as follows: 100 visits for any combination of physical therapy and occupational therapy	$10 Copay per visit 100% of Allowed Amount	80% of Allowed Amount

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Separate physical and occupational therapy limits apply to rehabilitative and Habilitative Services. Visit limits do not apply to Treatment of Autism Spectrum Disorders. Visit limits do not apply to Physiotherapy provided in conjunction with Home Health Care Services. Visit limits do not apply to speech therapy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Cardiac Rehabilitation, Benefits for Home Health Care Services, Benefits for Treatment of Autism Spectrum Disorder, and Benefits for Treatment of Speech, Hearing and Language Disorders.		
Medical Emergency Expenses The Preferred Provider and Out-of-Network Provider Copay will be waived if admitted to the Hospital.	$100 Copay per visit 100% of Allowed Amount	$100 Copay per visit 100% of Allowed Amount
Diagnostic X-ray Services	$10 Copay per visit Allowed Amount	$10 Copay per visit Allowed Amount
Radiation Therapy	Allowed Amount	Allowed Amount
Laboratory Procedures	$10 Copay per visit Allowed Amount	$10 Copay per visit Allowed Amount
Tests & Procedures	$10 Copay per visit Allowed Amount	$10 Copay per visit Allowed Amount
Injections	$10 Copay per visit Allowed Amount	$10 Copay per visit Allowed Amount
Chemotherapy	Allowed Amount	Allowed Amount
Prescription Drugs and Medicines Lawfully Obtainable Only with a Written Prescription from a Physician *See UHCP Prescription Drug Benefit Endorsement for additional information. Prescription Drugs covered under the Preventive Care Services benefit will be paid at the benefit levels shown under Preventive Care Services.	*UnitedHealthcare Pharmacy (UHCP), Retail Network Pharmacy $10 Copay per prescription Tier 1 $55 Copay per prescription Tier 2 $75 Copay per prescription Tier 3 up to a 31-day supply per prescription When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge). UHCP Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	50% of billed charge generic drug 50% of billed charge brand-name drug up to a 31-day supply per prescription

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount	80% of Allowed Amount
Durable Medical Equipment See also Benefits for Prosthetic Devices and Repair	Allowed Amount	Allowed Amount
Consultant Physician Fees	$10 Copay per visit 100% of Allowed Amount	80% of Allowed Amount
Dental Treatment See Dental Treatment for details regarding Covered Medical Services	Allowed Amount	80% of Allowed Amount
Mental Illness Treatment See Benefits for Treatment of Mental Disorders See also Benefits for Mental Health Wellness Examination No Deductible, Copays, or Coinsurance will be applied to services for one annual Mental Health Wellness Examination per Policy Year	**Inpatient:** Allowed Amount **Outpatient office visits:** $10 Copay per visit 100% of Allowed Amount **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs*:*** Allowed Amount	**Inpatient:** Allowed Amount **Outpatient office visits:** 80% of Allowed Amount **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount
Substance Use Disorder Treatment See Benefits for Treatment of Mental Disorders	**Inpatient:** Allowed Amount **Outpatient office visits:** $10 Copay per visit 100% of Allowed Amount **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs*:*** Allowed Amount	**Inpatient:** Allowed Amount **Outpatient office visits:** 80% of Allowed Amount **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount
Maternity See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy See Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion No Deductible, Copays, or Coinsurance will be applied See also Benefits for Abortion and Abortion Related Care	100% of Allowed Amount	100% of Allowed Amount

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups. See also Benefits for Cytologic Screening and Mammographic Examinations, Benefits for Maternity, Childbirth, Well-Baby and Post-Partum Care, Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services, and Benefits for Dependent Children Preventive Care	100% of Allowed Amount	80% of Allowed Amount
Reconstructive Breast Surgery Following Mastectomy See Benefits for Initial Prosthetic Devices and Reconstructive Surgery Incident to Mastectomy	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Treatment of Diabetes	Paid as any other Sickness	Paid as any other Sickness
High Cost Procedures	Allowed Amount	80% of Allowed Amount
Home Health Care See Benefits for Home Health Care	Allowed Amount	Allowed Amount
Hospice Care See Benefits for Hospice Care	Allowed Amount	Allowed Amount
Inpatient Rehabilitation Facility 60 days maximum per Policy Year	Allowed Amount	Allowed Amount
Skilled Nursing Facility 100 days maximum per Policy Year	Allowed Amount	Allowed Amount
Urgent Care Center	$10 Copay per visit 100% of Allowed Amount	$10 Copay per visit 100% of Allowed Amount
Hospital Outpatient Facility or Clinic	Allowed Amount	Allowed Amount
Approved Clinical Trials See also Benefits for Qualified Clinical Trials for Treatment of Cancer	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Allergy Treatment	Paid as any other Sickness	Paid as any other Sickness
Chiropractor Services	Paid as any other Sickness	Paid as any other Sickness
Dialysis	Allowed Amount	Allowed Amount
Family Planning	Paid as any other Sickness	Paid as any other Sickness
Fitness Benefit	See the Fitness Benefit in the Certificate of Coverage	See the Fitness Benefit in the Certificate of Coverage
Ostomy Supplies	Allowed Amount	Allowed Amount
Podiatry Care	Paid as any other Sickness	Paid as any other Sickness
Routine Hearing Exam	100% of Allowed Amount	80% of Allowed Amount

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Temporomandibular Joint Disorder	Paid as any other Sickness	Paid as any other Sickness
Weight Loss Programs	Paid as any other Sickness	Paid as any other Sickness
COVID-19 Testing and Services No Deductible, Copays, or Coinsurance will be applied See Benefits for COVID-19 Testing and Services	100% of Allowed Amount	100% of Allowed Amount
Adult Routine Eye Exam Limited to 1 eye exam per Policy Year	80% of Allowed Amount	80% of Allowed Amount

HPHC INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

Network and Out-of-Network Benefits

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

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

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

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call the Company at the number stated on their identification (ID) card to determine which providers participate in the Network.

Out-of-Network Benefits - these benefits apply when the Insured Person decides to obtain Covered Dental Services from out-of-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Out-of-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by an out-of-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. Insured Persons may be required to pay an out-of-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. When the Insured Person obtains Covered Dental Services from out-of-Network Dental Providers, the Insured Person must file a claim with the Company to be reimbursed for Allowed Dental Amounts.

What Are Covered Dental Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

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

Section 2: Benefits for Pediatric Dental Services

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

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

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

Network Benefits:

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

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

Out-of-Network Benefits:

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

Dental Services Deductible

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

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

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

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

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

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

Benefit Description

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Diagnostic Services - (Subject to payment of the Dental Services Deductible.)		
Evaluations (Checkup Exams) Limited to two times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient D0160 - Detailed and extensive oral evaluation - problem focused, by report	50%	50%
Intraoral Radiographs (X-ray) Limited to one series of films per 36 months. D0210 - Intraoral - comprehensive series of radiographic images D0709 - Intraoral - comprehensive series of radiographic images - image capture only D0372 - Intraoral tomosynthesis - comprehensive series of radiographic images D0387 - Intraoral tomosynthesis - comprehensive series of radiographic images - image capture only	50%	50%
The following services are limited to two per 12 months. D0220 - Intraoral - periapical first radiographic image	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0374 - Intraoral tomosynthesis - periapical radiographic image D0389 - Intraoral tomosynthesis - periapical radiographic image - image capture only D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only		
Any combination of the following services is limited to two series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0373 - Intraoral tomosynthesis - comprehensive series of radiographic images D0388 - Intraoral tomosynthesis - bitewing radiographic image - image capture only D0708 - Intraoral - bitewing radiographic image - image capture only	50%	50%
Limited to one time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only D0702 - 2-D Cephalometric radiographic image - image capture only	50%	50%
The following service is limited to two images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%	50%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 - 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0470 - Diagnostic casts	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only		
Preventive Services - (Subject to payment of the Dental Services Deductible.)		
Dental Prophylaxis (Cleanings) The following services are limited to two times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%	50%
Fluoride Treatments The following services are limited to two times every 12 months. D1206 - Topical application of fluoride varnish D1208 - Topical application of fluoride - excluding varnish	50%	50%
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%	50%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed - bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant		
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)		
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit. D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)	50%	50%
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)		
The following services are subject to a limit of one time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2740 - Crown - porcelain/ceramic D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 - Crown - titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown		
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%	50%
The following services are limited to one time per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth D2950 - Core buildup, including any pins when required D2951 - Pin retention - per tooth, in addition to restoration	50%	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	50%	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	50%	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration) D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)		
The following services are not subject to a frequency limit. D3310 - Endodontic therapy, anterior tooth (excluding final restoration) D3320 - Endodontic therapy, premolar tooth (excluding final restoration) D3330 - Endodontic therapy, molar tooth (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit	50%	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy (each additional root) D3450 - Root amputation - per root D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	50%	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%	50%
The following services are limited to one every 36 months. D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard tissue	50%	50%
The following services are limited to one every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft retained natural tooth - first site in quadrant D4286 - Removal of non-resorbable barrier	50%	50%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure	50%	50%
The following services are not subject to a frequency limit.	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns		
The following services are limited to one time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%	50%
The following service is limited to a frequency to one per lifetime. D4355 - Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	50%	50%
The following service is limited to four times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to a frequency of one every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5213 - Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant		
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5511 - Repair broken complete denture base - mandibular	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture (each tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture		
The following services are limited to rebasing performed more than six months after the initial insertion with a frequency limitation of one time per 12 months. D5710 - Rebase complete maxillary denture D5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct) D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)	50%	50%
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)		
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic - titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic	50%	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%	50%
The following services are limited to one time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6792 - Retainer crown - full cast noble metal		
The following services are not subject to a frequency limit. D6930 - Re-cement or re-bond FPD D6980 - FPD repair necessitated by restorative material failure	50%	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)		
The following services are not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root D7210 - Surgical removal of erupted tooth requiring removal of bone, sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal, impacted teeth only	50%	50%
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%	50%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth	50%	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces, per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant		
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%	50%
The following services are not subject to a frequency limit. D7509 - Marsupialization of odontogenic cyst D7510 - Incision and drainage of abscess, intraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva	50%	50%
The following services are limited to one every 36 months. D7956 - Guided tissue regeneration, edentulous area - resorbable barrier, per site D7957 - Guided tissue regeneration, edentulous area - non-resorbable barrier, per site	50%	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)		
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative treatment of dental pain - per visit	50%	50%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutes D9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Covered only when clinically Necessary D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	50%	50%
The following services are limited to one guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch	50%	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)		
The following services are limited to one time every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 - Surgical placement transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain/ ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6095 - Repair implant abutment, by report D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys		

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant replacement D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 - Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys		
The following services are not subject to a frequency limit. D6105 - Removal of implant body not requiring bone removal or flap elevation D6197 - Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	50%	50%
The following services are limited to one every 36 months. D6106 - Guided tissue regeneration - resorbable barrier, per implant D6107 - Guided tissue regeneration - non-resorbable barrier, per implant	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts.		
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Network Benefits**	**Out-of-Network Benefits**
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.		
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular	50%	50%

Section 3: Pediatric Dental Exclusions

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

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

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

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

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

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

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

Section 5: Defined Terms for Pediatric Dental Services

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

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

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

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

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

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

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

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

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

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

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

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

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

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

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

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

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

Out-of-Network Benefits - benefits available for Covered Dental Services obtained from out-of-Network Dentists.

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

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

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

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

HPHC INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

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

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

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

Network Benefits:

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

Out-of-Network Benefits:

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

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

Policy Deductible

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

What Are the Benefit Descriptions?

Benefits

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

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

Frequency of Service Limits

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

Routine Vision Examination

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

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

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

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

Eyeglass Lenses

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

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

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

Eyeglass Frames

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

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

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

Contact Lenses

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

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

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

Necessary Contact Lenses

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

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

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

Benefits are available to Insured Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes:
  - A comprehensive examination of visual functions.
  - The prescription of corrective eyewear or vision aids where indicated.
  - Any related follow-up care.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of $10.	80% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of $25.	80% of the billed charge.
• Bifocal		100% after a Copayment of $25.	80% of the billed charge.
• Trifocal		100% after a Copayment of $25.	80% of the billed charge.
• Lenticular		100% after a Copayment of $25.	80% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%	80% of the billed charge.
• Eyeglass frames with a retail cost of $130 - 160.		100% after a Copayment of $15.	80% of the billed charge.
• Eyeglass frames with a retail cost of $160 - 200.		100% after a Copayment of $30.	80% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		100% after a Copayment of $50.	80% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	80% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Contact Lenses Fitting & Evaluation	Once per year.	100%	100% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection	Limited to a 12 month supply.	100% after a Copayment of $25.	80% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $25.	80% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Low Vision Care Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low vision testing		100% of the billed charge.	80% of the billed charge.
• Low vision therapy		100% of the billed charge.	80% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

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

By facsimile (fax):
248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

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

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

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

HPHC INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When Are Benefits Available for Prescription Drug Products?

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

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

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

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a Physician and only after ¾ of the original Prescription Drug Product has been used. For select controlled medications filled at a retail Network Pharmacy, refills are available when 90% of the original Prescription Drug Product has been used. For select controlled medications filled at a mail order Network Pharmacy, refills are available when 80% of the original Prescription Drug Product has been used.

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

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

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

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

Copayment and/or Coinsurance Amount

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

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

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

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

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

How Do Supply Limits Apply?

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

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

When a Prescription Drug Product is dispensed from a mail order Network Pharmacy or a Preferred 90 Day Retail Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Policy Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

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

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

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

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

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

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

Designated Pharmacies

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

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

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

If the Insured is directed to a Designated Pharmacy and has informed the Company of their decision not to obtain their Prescription Drug Product from a Designated Pharmacy, benefits will be paid based on the out-of-Network Benefit for that Prescription Drug Product.

For a Specialty Prescription Drug Product, if the Insured chooses to obtain their Specialty Prescription Drug Product at a Non-Preferred Specialty Network Pharmacy, the Insured will be required to pay 2 times the retail Network Pharmacy

Copayment and/or 2 times the retail Network Pharmacy Coinsurance (up to 50% of the Prescription Drug Charge) based on the applicable tier.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

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

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

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

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

The following supply limits apply to Specialty Prescription Drug Products.

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

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

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

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

Do Prior Authorization Requirements Apply?

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

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

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

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

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

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

When Does the Company Limit Selection of Pharmacies?

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

Coverage Policies and Guidelines

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

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

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

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

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

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they 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. This includes data sources such as Medi-Span that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician will be classified as Brand-name by the Company.

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

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

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

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

Exceptions:

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

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

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

Network Pharmacy means a pharmacy that has:

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

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

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

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

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

PPACA means Patient Protection and Affordable Care Act of 2010.

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

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

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

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

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

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

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

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

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

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

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

Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products at www.uhcsr.com/wpi or call *Customer Service* at 1-855-828-7716.

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

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

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

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for a Medical Emergency.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
5. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications for certain diseases and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
9. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
10. Certain unit dose packaging or repackagers of Prescription Drug Products.
11. Medications used for cosmetic or convenience purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
13. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Company's PDL Management Committee.
14. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are placed on Tier-3.)
15. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug Product that was previously excluded under this provision.
16. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury, except as required by state mandate.

17. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
19. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by the Company. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
20. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
21. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
22. Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
23. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
24. Durable medical equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which benefits are provided in the Policy. Prescribed and non-prescribed outpatient supplies. This exclusion does not apply to diabetic supplies and inhaler spacers specifically stated as a Prescription Drug Product that is a Covered Medical Expense.
25. Diagnostic kits and products, including associated services.
26. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
27. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.
28. A Prescription Drug Product that contains marijuana, including medical marijuana.

Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-800-977-4698. The Company will notify the Insured Person of the Company's determination within 72 hours.

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

Urgent Requests

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

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-800-977-4698. The *Independent Review Organization (IRO)* will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-800-977-4698 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

HPHC INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

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

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

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

Assistance and Evacuation Benefits

DEFINITIONS

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

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

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

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

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

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

MEDICAL EVACUATION AND REPATRIATION BENEFITS

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

(including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the emergency medical evacuation.

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

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

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

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

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

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

CONDITIONS AND LIMITATIONS

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

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

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

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

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

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

Additional Assistance Services

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

MEDICAL ASSISTANCE SERVICES

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

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

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

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

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

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

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

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

WORLDWIDE DESTINATION INTELLIGENCE

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

TRAVEL ASSISTANCE SERVICES

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

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

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

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

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

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

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

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

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

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

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

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

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

NON-DISCRIMINATION NOTICE

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

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

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

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

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

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

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

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

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

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

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

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

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

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

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

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

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

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

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

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

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

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

Cherokee
ᎦᏬᏂᎯᏍᏗ ᎤᎾᏓᏍᏕᎸᏗ ᎤᎾᏓᏡᎬᎢ ᏂᎯ ᎡᎶᎯᏍᎢᏍᏓᏁᏗᎢ ᏂᏓᎬᏩᎶᏛ ᎠᏎᏍᎢ. ᎨᏍᏗ ᎠᏂ ᏫᏏᎳᏛᏓ 1-866-260-2723.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeļok wōņāān. Jouj im kallǫk 1-866-260-2723.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Syriac- Assyrian
ܚܕܡܬܐ ܕܥܘܕܪܢܐ ܕܠܫܢܐ، ܡܬܝܗܒܢ، ܐܢܬܘܢ ܩܕܡ ܡܓܢܐ. ܒܒܥܘܬܐ ܩܪܘ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

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

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

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2733

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

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

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

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

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

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

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

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