UNITEDHEALTHCARE INSURANCE COMPANY

STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for Students of

Rutgers

Post-Doctoral Fellows, Graduate Fellows,
Teaching and Graduate Assistants (TA's & GA's)

2023-2024

This Certificate of Coverage is Part of Policy # 2023-202826-1

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

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.

THIS CERTIFICATE IS SUBJECT TO THE LAWS OF THE STATE OF NEW JERSEY

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Introduction

Welcome to the UnitedHealthcare Student Resources Student Health Insurance Plan. This plan is underwritten by UnitedHealthcare Insurance Company.

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

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-866-599-4427. The Insured can also write to the Company at:

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

Section 1: Who Is Covered

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

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

All full-time Postdoctoral Fellows and less than full appointment Teaching and Graduate Assistants (upon determination by University Human Resources) and Graduate Fellows who have been awarded a Full Fellowship from internal or external sources (upon determination by the Graduate School Dean's Office) are eligible to enroll in this insurance plan.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's legal spouse, Civil Union partner, or Domestic Partner and dependent children, including any child for which the Named Insured is under court order to provider coverage, up to 26 years of age. Dependent child coverage may continue after age 26 under specific circumstances. See the Definitions section of this Certificate for the specific requirements needed to meet Domestic Partner eligibility.

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

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

1. If a Named Insured has Dependents, the Dependents become eligible on the date the Named Insured 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 enters into a Civil Union or 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 meets the Definition of a Dependent, or a Newborn Infant or an Adopted or Foster Child.

Dependent eligibility expires concurrently with that of the Named Insured.

Section 2: Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., September 1, 2023. The Insured Person's coverage becomes effective on the first day of the period for which premium contributions are paid or the date the enrollment form and full premium contributions are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 31, 2024. The Insured Person's coverage terminates on that date or at the end of the period through which premium contributions are 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 contribution payment for late enrollees. Refunds of premium contributions are allowed only upon entry into the armed forces.

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

Section 3: Extension of Benefits after Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the Termination Date.

However, if an Insured is pregnant on the Termination Date and the conception occurred while covered under this Policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.

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

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

Section 4: Pre-Admission Notification

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

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

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

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

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

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

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

Preferred Providers in the local school area are:

UnitedHealthcare Choice Plus

Preferred Provider Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities.

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

The Insured may also call the Customer Service Department at 1-866-599-4427 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 1-866-599-4427 and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com.

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

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. An Insured may call the Company at 1-866-599-4427 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.

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

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

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

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

Out-of-Network Provider Benefits
Except as described below under the No Surprises Act provision, the Insured Person is responsible for paying, directly to the Out-of-Network Provider, any difference between the amount the provider bills the Insured and the amount the Company pays for Allowed Amounts.

This 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.

No Surprises Act

1. For Ancillary Services received at certain Preferred Provider facilities on a non-Medical Emergency basis from Out-of-Network Provider Physicians, 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 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 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 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.

Special Provider Arrangements

UMDNJ Hospital, Rutgers Physicians and The Psychological Clinic have agreed to accept the Allowed Amount for treatment rendered to Insureds. Eligible services provided by UMDNJ Hospital, Rutgers Physicians and The Psychological Clinic will be paid at 90% of the Preferred Allowance rates for Covered Medical Expenses, up to the Schedule of Benefits limits.

Insureds will be responsible for all out of pocket expenses in excess of the Policy limits contained in the Schedule of Benefits.

Out-of-Network Exception Request

If the Company's Preferred Provider network does not include a Preferred Provider who is qualified, accessible, and available to perform the Insured's required Medically Necessary services covered under the Policy, then the Insured Person has the right to request to use an Out-of-Network provider to obtain the Medically Necessary covered services at the Preferred Provider level of cost sharing.

Section 6: Medical Expense Benefits

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

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

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

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

Inpatient

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

2. **Intensive Care.**
   Services provided when an Insured is confined in an Intensive Care unit.

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 Postpartum Care and Routine Newborn Care in the Mandated Benefits section.

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.

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

<u>Outpatient</u>

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

    When these services are performed in a Physician’s office, benefits are payable under outpatient Physician’s Visits.

12. **Day Surgery Miscellaneous.**
    Facility charge and the charge for services and supplies in connection with outpatient day surgery. Benefits do not include non-scheduled surgery or 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 Physiotherapy.

Benefits include the following services when performed in the Physician's office:

- Surgery.

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 Audiology and Speech Language Pathology in the Mandated Benefits section.

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.

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

The Insured should use emergency services, including calling 911 or other telephone access systems utilized to contact pre-hospital emergency services, when appropriate for treatment of a Medical Emergency.

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.**
Radiation therapy benefits are provided as indicated in the 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.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.
- Dialysis and hemodialysis.

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.**
Chemotherapy benefits are provided as indicated in the Schedule of Benefits.

24. **Prescription Drugs.**
Prescription Drug Benefits are provided as indicated in the Schedule of Benefits.

Other

25. **Ambulance Services.**
Ambulance service benefits are provided as indicated in the 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.
- Hospital-type beds.
- Wheelchairs.

Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

See also Benefits for Orthotic and Prosthetic Appliances in the Mandated Benefits section.

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

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.
- Surgical removal of bony, impacted teeth.

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

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

29. **Mental Health Condition and Substance Use Disorder Treatment.**
Benefits will be paid as indicated in the Schedule of Benefits for the following services:
- Inpatient treatment while confined to a Hospital.
- Residential treatment.
- Partial hospitalization/day treatment received at a Hospital.
- Outpatient treatment.
- Intensive outpatient treatment.

Benefits for Inpatient treatment and residential treatment include room and board in a semi-private room (a room with two or more beds).

Services include the following:
- Diagnostic evaluations, assessments and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Benefit also include coverage for the treatment of autism and other Developmental Disabilities. When an Insured Person's primary diagnosis is autism or another Developmental Disability, the Company will provide benefits for Covered Medical Expenses incurred for Medically Necessary:
- Occupational therapy.
- Physical therapy.
- Speech therapy, including speech and language pathology.

Benefits for these therapies shall be provided as prescribed in the treatment plan by the Insured Person's Physician. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

The treatment plan must include all elements necessary to appropriately provide benefits, including but not limited to:

- A diagnosis.
- Proposed treatment by type, frequency, and duration.
- The anticipated outcomes states as goals.
- The frequency by which the treatment plan will be updated.
- The treating Physician's signature.

The Company may request an updated treatment plan once every six months to review Medical Necessity, unless a more frequent review is agreed upon by the Company and the Insured's Physician, due to emerging clinical circumstances.

Any visit limits in the Policy for physical, occupational, and speech therapy shall not be applied to the treatment of autism or other Developmental Disability.

"Developmental disability or developmentally disabled," which is also referred to as neurodevelopmental disability or neurodevelopmentally disabled, means a neurodevelopmental disorder which is referenced by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders.

New Jersey Early Intervention System (NJEIS) Family Cost Share Expense

Benefits also include any Covered Medical Expenses incurred by the Insured Person for early intervention services provided under an individualized family service plan through the New Jersey Early Intervention System (NJEIS). The NJEIS, under the Division of Family Health Services, implements New Jersey's statewide system of services for infants and toddlers, birth to age three, with developmental delays or disabilities, and their families.

Benefits include reimbursement of a portion of the family cost share expense incurred by an Insured Person for the provision of certain health care services obtained in accordance with a treatment plan developed as a result of, or in conjunction with, an Individualized Family Service Plan (IFSP) for a child determined eligible for early intervention services through the NJEIS.

The IFSP is both a plan and a process. The plan is a written document that identifies the outcomes, services and supports needed for the child and family. The process is ongoing assessment to gather, share, and exchange information between the family and the early intervention practitioners to help parents make informed choices about early intervention services and other needed services for the child and family.

The NJEIS family cost share is a progressive Copayment per hour of direct services provided in accordance with an IFSP that is based upon family size and NJEIS determined income along the federal poverty level guidelines.
In order to be eligible for reimbursement, the Insured Person must:
- Be eligible for early intervention services through the NJEIS.
- Have been diagnosed with autism spectrum disorder or another Developmental Disability.

- Have received physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services.

The portion of the family cost share attributable to such services is a Covered Medical Expense under the Policy.

The therapy services an Insured Person receives through NJEIS do not reduce the therapy services otherwise available under the Policy.

30. **Maternity.**
Same as any other Sickness. See Benefits for Postpartum Care and Routine Newborn Care in the Mandated Benefits section.

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

32. **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*.

33. **Reconstructive Breast Surgery Following Mastectomy.**
Same as any other Sickness and in connection with a covered mastectomy. See Benefits for Reconstructive Breast Surgery in the Mandated Benefits section.

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

35. **Home Health Care.**
See Benefits for Home Health Care in the Mandated Benefits Section.

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

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

37. **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 14 days of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

38. **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 14 days following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

39. **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.

40. **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.

41. **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.

42. **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.

Organ and tissue donations save lives. Organ, eye, and tissue donations give people a second chance at life. To learn more about the benefits of organ and tissue donation and transplantation, or to register as a donor, visit the NJ Sharing Network website at: https://www.njsharingnetwork.org.

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

44. **Acupuncture in Lieu of Anesthesia.**
Acupuncture services provided in lieu of anesthesia are provided as indicated in the Schedule of Benefits.

45. **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.

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

Section 7: Mandated Benefits

BENEFITS FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of diabetes if recommended or prescribed by a Physician or nurse practitioner/clinical nurse specialist: blood glucose monitors and blood glucose monitors for the legally blind; test strips for glucose monitors and visual reading and urine testing strips; insulin; injection aids; cartridges for the legally blind; syringes; insulin pumps and appurtenances thereto; insulin infusion devices; and oral agents for controlling blood sugar. Benefits shall also include self-management education to ensure that an Insured Person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet.

Benefits provided for self-management education and education relating to diet shall be limited to visits Medically Necessary upon the diagnosis of diabetes; upon diagnosis by a Physician or nurse practitioner/clinical nurse specialist of a significant change in the Insured’s symptoms or conditions which necessitate changes in that person's self-management; and upon determination of a Physician or nurse practitioner/clinical nurse specialist that reeducation or refresher education is necessary.

Diabetes self-management education shall be provided by a dietitian registered by a nationally recognized professional association of dietitians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

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

BENEFITS FOR TREATMENT OF INHERITED METABOLIC DISEASE

Benefits will be paid the same as any other Sickness for Covered Medical Expenses incurred in the therapeutic treatment of Inherited Metabolic Diseases, including the purchase of Medical Foods and Low Protein Modified Food Products, when diagnosed and determined to be a Medical Necessity by the Physician.

“Inherited metabolic disease” means a disease caused by an inherited abnormality of body chemistry for which testing is mandated pursuant to P.L. 1977, c. 321 (c. 26:2-110 et seq.).

“Low protein modified food product” means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein.

"Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a Physician.

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

BENEFITS FOR INPATIENT COVERAGE FOR MASTECTOMIES

Benefits will be paid the same as any other Sickness for a minimum of 72 hours of inpatient care following a modified radical mastectomy and a minimum of 48 hours of inpatient care following a simple mastectomy.

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

BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness following a mastectomy on one breast or both breasts for reconstructive breast surgery and surgery to restore and achieve symmetry between the two breasts including the cost of prosthesis. The costs of outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer shall be included as a part of the outpatient x-ray or radiation therapy coverage.

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

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for a mammogram according to the following guidelines:

1. One baseline mammogram for women who are less than forty years of age;
2. One mammogram every year for women age forty and over.
3. In the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age intervals as deemed Medically Necessary by the woman's Physician.

Benefits shall also be provided for an ultrasound evaluation, a magnetic resonance imaging scan, a three-dimensional mammography, or other additional testing of an entire breast or breasts, after a baseline mammogram examination:

1. If the mammogram:
   - Demonstrates extremely dense breast tissue.
   - Is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast issue.
2. If the Insured has additional risk factors for breast cancer, including but not limited to:
   - Family history of breast cancer.
   - Prior personal history of breast cancer.
   - Positive genetic testing.
   - Extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
   - Other indications as determined by the Insured's Physician.

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

BENEFITS FOR DIGITAL TOMOSYNTHESIS OF THE BREAST

Benefits will be provided for digital tomosynthesis to detect or screen for breast cancer.

Benefits for digital tomosynthesis conducted to detect or screen for breast cancer in women 40 year of age and over:

1. Shall not be subject to any Deductible, Copayment, or Coinsurance.
2. Shall be subject to the limitations or any other provisions of the Policy.

Benefits for digital tomosynthesis conducted for diagnostic purposes in women on any age shall be paid as any other Sickness and subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR PROSTATE CANCER TESTING (PSA)

Benefits will be paid the same as any other Sickness for an annual medically recognized diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen (PSA) test for men age 50 and over who are asymptomatic and for age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

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

BENEFITS FOR COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for colorectal cancer screening at regular intervals for Insured Persons age 50 and over and for Insured Persons of any age who are considered to be at high risk for colorectal cancer.

"High risk for colorectal cancer" means a person has:

1. A family history of: familial adenomatous polyposis; hereditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
2. Chronic inflammatory bowel disease; or
3. A background, ethnicity or lifestyle that the Physician believes puts the person at elevated risk for colorectal cancer.

The methods of screening for which benefits shall be provided shall include:

1. A screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or
2. The most reliable, medically recognized screening test available.

The method and frequency of screening to be utilized shall be in accordance with the most recent published guidelines of the American Cancer Society and as determined Medically Necessary by the Insured Person's Physician, in consultation with the Insured Person.

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

BENEFITS FOR TREATMENT OF WILM'S TUMOR

Benefits will be paid the same as any other Sickness for the treatment of Wilm's tumor, including autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful, notwithstanding that any such treatment may be deemed experimental or investigational.

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

BENEFITS FOR AUDIOLOGY AND SPEECH LANGUAGE PATHOLOGY

Benefits will be paid the same as any other Sickness for audiology and speech language pathology when such services are determined by a Physician to be Medically Necessary and are performed or rendered to the Insured by a licensed audiologist or speech language pathologist.

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

BENEFITS FOR PAP SMEAR

Benefits will be paid the same as any other Sickness for an annual Pap Smear or a Pap Smear done more frequently than annually if recommended by a Physician. The benefit shall include an initial Pap Smear and any confirmatory test when Medically Necessary and are ordered by the Covered Person's Physician and includes all laboratory cost associated with the initial Pap Smear and any such confirmatory test.

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

BENEFITS FOR HOME HEALTH CARE

Benefits will be paid the same as any other Sickness for Home Health Care as hereinafter defined.

"Home Health Care" means those nursing and other home health care services rendered to an Insured who is the patient in his place of residence, under all the following conditions:

1. On a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than three days) basis.
2. If continuing Hospitalization would otherwise have been required if home health care were not provided.
3. Pursuant to a Physician's written order and under a plan of care established by the responsible Physician working with a Home Health Care Provider. The Physician must review the plan monthly and certify monthly that continued confinement in a Hospital would otherwise be required. That Physician may not be related to the Home Health Care Provider by ownership or contract. All care plans shall be established within 14 days following commencement of home health care.
4. Home health care services will include benefits for hemophilia, including expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of State approved hemophilia treatment center. These benefits shall be provided to the same extent as any other Sickness under the Policy. “Blood product” includes, but is not limited to Factor VIII, Factor IX and, cryoprecipitate. “Blood infusion equipment” includes, but is not limited to, syringes and needles.

"Home Health Care Provider" means a home health care agency which is certified to participate as a home health agency under Title XVIII of the Social Security Act or licensed by the New Jersey Department of Health and Senior Services as a home health agency.

"Home Health Care Services" means any of the following services which are Medically Necessary to achieve the plan of care referred to in condition (3) above and are provided for the care of the Insured Person: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this Policy if the Insured were in a Hospital; and any diagnostic or therapeutic service, including surgical services performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, to the extent such service would be covered by this Policy if performed as an inpatient Hospital service, provided that service is performed as part of the plan of care.

LIMITATIONS - Home Health Care Benefits are subject to the following limitations:

1. Services must follow a Hospital Confinement of at least three consecutive days. Services must begin not more than three days after the end of that confinement.
2. Any visit by a member of a home health care team on any day will be considered one home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months.
3. The amount payable for a home health care visit shall not exceed for each of the first three days on which services are provided the daily room and board benefit provided by this Policy during the prior confinement; for each subsequent day of such services, the amount payable shall not exceed one-half of the daily room and board benefit provided by this Policy during the prior confinement.
4. The services and supplies must be furnished and charged for by a Home Health Care Provider.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL SERVICES

Benefits will be paid the same as any other Sickness for an Insured who is severely disabled or a child age five or under for Covered Medical Expenses incurred for: (1) general anesthesia and hospitalization for dental services; or (2) a medical condition covered by the Policy which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services are provided.

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 Medically Necessary expenses incurred in the diagnosis and treatment of infertility for an Insured Person. Benefits include but are not limited to the following services related to Infertility: diagnosis and diagnostic tests; medications; surgery; in vitro fertilization; embryo transfer; artificial insemination; gamete intra fallopian transfer; zygote intra fallopian transfer; intracytoplasmic sperm injection; and four completed egg retrievals per lifetime of the Insured Person (excluding egg retrievals at the person's own expense.)

In vitro fertilization, gamete intra fallopian transfer and zygote intra fallopian transfer shall be limited to an Insured Person who: (a) has used all reasonable, less expensive and medically appropriate treatments and is still unable to become pregnant or carry a pregnancy; (b) has not reached the limit of four complete egg retrievals; and (c) is 45 years of age or younger.

Infertility means the disease or condition that results in the abnormal function of the reproductive system as determined pursuant to the American Society for Reproductive Medicine practice guidelines by a Physician who is Board Certified or Board Eligible in Reproductive Endocrinology and Infertility or in Obstetrics and Gynecology or that the Insured Person has met one of the following conditions:

1. A male is unable to impregnate a female.
2. A female with a male partner and under 35 years of age is unable to conceive after 12 months of unprotected sexual intercourse.
3. A female with a male partner and 35 years of age or over is unable to conceive after six months of unprotected sexual intercourse.
4. A female without a male partner and under 35 years of age who is unable to conceive after 12 failed attempts of intrauterine insemination under medical supervision.
5. A female without a male partner and 35 years of age or over who is unable to conceive after six failed attempts of intrauterine insemination under medical supervision.
6. Partners are unable to conceive as a result of involuntary medical sterility.
7. A person is unable to carry a pregnancy to live birth.
8. A previous determination of infertility.

The benefits shall be provided to the same extent as for other pregnancy-related procedures under the Policy, except that the services provided for in this section shall be performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists.

Infertility resulting from voluntary sterilization procedures are not covered under this benefit.

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

BENEFITS FOR FERTILITY PRESERVATION SERVICES

Benefits will be paid the same as any other Sickness for Standard Fertility Preservation Services when a Medically Necessary treatment may Directly or Indirectly Cause Iatrogenic Infertility.

"Iatrogenic infertility" means an impairment of fertility caused by surgery, radiation, chemotherapy, or other medical treatment affecting reproductive organs or processes.

"Standard fertility preservation services" means procedures consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the new Jersey Department of Health. Standard Fertility Preservation Services shall not include the storage of sperm or oocytes.

"Directly or indirectly cause" means a medical treatment with a likely side effect of Iatrogenic Infertility as established by the American Society of Reproductive Medicine, the American Society of Clinical Oncology, or as defined by the New Jersey Department of Health.

Benefits determinations shall not be based on Insured's:

1. Life expectancy.
2. Present or predicted disability.
3. Degree of medical dependency.

4. Perceived quality of life.
5. Other health conditions.
6. Personal characteristics, including age, sex, sexual orientation, marital status, or gender identity.

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

BENEFITS FOR ORTHOTIC AND PROSTHETIC APPLIANCES

Benefits will be paid based on the Medicare allowance amount for Orthotic and Prosthetic Appliances when such appliances are determined by a Physician to be Medically Necessary and are obtained by the Insured from a licensed orthotist or prosthetist or a certified pedorthist.

"Orthotic appliance" means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

"Prosthetic appliance" means any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs, or other devices which should not by their use have a significantly detrimental impact upon the muscular skeletal functions of the body.

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

BENEFITS FOR HEARING AIDS

Benefits will be paid the same as any other Sickness for Medically Necessary Covered Medical Expenses incurred for the purchase of a hearing aid for an Insured Person. Benefits include one hearing aid for each ear when prescribed or recommended by a licensed Physician or audiologist.

Benefits are limited to one hearing aid per each hearing-impaired ear during a 24-month period.

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

BENEFITS FOR CONTRACEPTIVE SERVICES AND DEVICES

Benefits will be provided with no Deductible, Copayment or Coinsurance for the following services, drugs, devices, products, and procedures when received from a Preferred Provider:

1. Any contraceptive drug, device or product approved by the United States Food and Drug Administration (FDA), which shall subject to all of the following conditions:
   - If there is a therapeutic equivalent of a contraceptive drug, device or product approved by the FDA, coverage shall be provided for either the requested contraceptive drug, device or product or for one or more therapeutic equivalents of the requested drug, device or product.
   - Coverage shall be provided without a prescription for all contraceptive drugs available for over-the-counter sale that are approved by the FDA.
   - Coverage shall be provided without any infringement upon an Insured's choice of contraception and Medical Necessity shall be determined by the Insured's Physician for covered contraceptive drugs, devices or other products approved by the FDA.
2. Voluntary male and female sterilization.
3. Patient education and counseling on contraception.
4. Services related to the administration and monitoring of drugs, devices, products and services required under this benefit, including but not limited to:
   - Management of side effects.
   - Counseling for continued adherence to a prescribed regimen.
   - Device insertion and removal.
   - Provision of alternative contraceptive drugs, devices or products deemed medically appropriate in the judgement of the Insured's Physician.
   - Diagnosis and treatment services provide pursuant to, or as a follow-up to, a service required under this benefit.

Benefits shall also include prescriptions for dispensing of contraceptives for up to 12-month period at one time.

Any other Contraceptive Services and Devices covered under the Policy will be paid the same as any other Sickness and shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR NON-STANDARD INFANT FORMULAS

Benefits will be paid the same as any other Prescription Drugs for the purchase of specialized non-standard infant formulas, when the Insured infant's Physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be Medically Necessary, and when the Insured infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. This benefit may be subject to utilization review, including periodic review, of the continued Medical Necessity of the specialized infant formula.

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

BENEFITS FOR DONATED HUMAN BREAST MILK

Benefits will be paid the same as any other Sickness for Covered Medical Expenses incurred in the provision of pasteurized donated human breast milk, which may include human milk fortifiers, if indicated by the prescribing Physician.

Benefits are subject to the following conditions:

1. The Insured is an infant under the age of six months.
2. The milk is obtained from a human milk bank that meets the quality guidelines established by the Department of Health.
3. A Physician has issued an order for an infant who:
    a. Is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce maternal breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; or
    b. Meets any of the following:
        - Has a body weight below healthy levels determined by the Physician.
        - Has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.
        - Has a congenital or acquired condition that may benefit from the use of donor breast milk as determined by the Department of Health.

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

BENEFITS FOR LEAD POISONING, NEWBORN HEARING LOSS AND CHILDHOOD IMMUNIZATIONS

Benefits will be paid the same as any other Sickness, except that no Deductible will be applied, for the following services:

1. Screening by blood lead measurement for lead poisoning for eligible Dependent Children, including confirmatory blood testing as specified by the New Jersey Department of Health and Senior Services and including medical evaluation and any necessary medical follow-up or treatment for lead poisoned eligible Dependent Children.
2. Screening for Newborn Hearing Loss by appropriate electrophysiologic screening measures and periodic monitoring of eligible Dependent Infants for delayed onset hearing loss.
3. All childhood Immunizations as recommended by the Advisory on Immunization Practices of the United States Public Health Service and the New Jersey Department of Health.

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

BENEFITS FOR POSTPARTUM CARE AND ROUTINE NEWBORN CARE

Benefits will be paid the same as any other Sickness for expenses incurred for a mother and her newly born child in a Hospital for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section.

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

BENEFITS FOR ORAL CHEMOTHERAPY DRUGS

Benefits will be paid the same as any other Prescription Drug for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the policy; provided that the Copayment, Coinsurance, and Deductibles are at least as favorable to an Insured Person as the Copays, Coinsurance or Deductibles that apply to intravenous or injected anticancer medications.

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

BENEFITS FOR TREATMENT OF SICKLE CELL ANEMIA

Benefits will be paid the same as any other Sickness for Medically Necessary Covered Medical Expenses incurred for the treatment of sickle cell anemia.

Benefits will be paid the same as any other Prescription Drug for medications prescribed for the treatment of sickle cell anemia.

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 MEDICATION SYNCHRONIZATION

Benefits for Prescription Drugs shall include the following:

1. A prorated daily Copayment amount for Prescription Drugs that are dispensed by a Network Pharmacy for less than a 30 day supply if the Physician or pharmacist that the fill or refill is in the best interest of the Insured Person or is for the purpose of synchronizing the Insured Person's chronic medications.
2. Coverage for a Prescription Drug for the treatment of a chronic Sickness which is dispensed in accordance with a plan between the Insured Person, the Physician, and the pharmacist to synchronize the refilling of multiple Prescription Drugs for the Insured Person.
3. Dispensing fees, if any, based exclusively on the total number of prescriptions dispensed.

This section does not apply to prescriptions for opioid analgesics. Opioid analgesics are drugs in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in mediate release or extended release form, and whether or not combined with other drug substances to form a single drug product or dosage form.

Medication synchronization shall be provided on at least one occasion per Policy Year, per Insured Person.

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

BENEFITS FOR BREASTFEEDING SUPPORT

Benefits will be provided for comprehensive lactation support, counseling, and consultation, and the costs for renting or purchasing breastfeeding equipment, in conjunction with each birth, for the duration of breastfeeding for the Insured Person, with no Cost-sharing.

Comprehensive Lactation Counseling and Lactation Consultation includes:

1. In-person, one-on-one Lactation Counseling and Lactation Consultation, subject to the following conditions:

    a. Benefits will include visits that occur inside and outside a Hospital or office setting. In-person Lactation Counseling and Lactation Consultation will be covered regardless of location of service and will include home visits.
    b. Lactation Counseling and Lactation Consultation will be made available within 24 hours of notification of need.
2. Telephonic Lactation Assistance will be covered in addition to, and not as a substitute for, in-person, one-on-one Lactation Counseling or Lactation Consultation, if an Insured requests in-person, one-on-one Lactation Counseling or Lactation Consultation. The Telephonic Lactation Assistance will be made available within 12 hours of notification of need.
3. Group Lactation Counseling will be covered in addition to, and not as a substitute for, in-person, one-on-one Lactation Counseling or Lactation Consultation, if an Insured requests in-person, one-on-one Lactation Counseling or Lactation Consultation. Group counseling will include educational classes and support groups.
4. Prior authorization, prescriptions, or referrals are not required for any Lactation Counseling or Lactation Consultation.

Benefits for breastfeeding equipment include:

1. Purchase of a single-user breast pump, subject to the following conditions:
    a. The purchase of a double electric breast pump, or a manual pump in lieu of the double electric breast pump, at the Insured’s request.
    b. A double electric breast pump of sufficient power and durability to establish and maintain milk supply for the duration of breastfeeding.
    c. Prior authorization, prescriptions, or Medical Necessity documentation are not required for the breast pump.
    d. Benefits are available at any time during pregnancy and during the postpartum period. Benefits will continue for the duration of breastfeeding, as defined by the Insured.
    e. Repair and replacement of a breast pump, if necessary.
2. Benefits for the purchase of a single-user breast pump, Breast Pump Kits, flanges, and other lactation accessories will be furnished within:
    a. 48 hours of notification of need, if requested after the birth of the child.
    b. By the later of two weeks before the Insured’s expected due date or 72 hours after notification, if requested prior to the birth of the child.
    c. If the Company cannot ensure an Insured received breastfeeding equipment within 48 hours, an Insured may purchase the equipment and the Company will reimburse all out-of-pocket expenses incurred by the Insured, including any balance billing amounts.

Benefits will also include the rental or purchase of a multi-user breast pump subject to the following conditions:

1. Benefits will be provided for multi-user breast pump upon recommendation of a Physician.
2. The Company will determine whether benefits are provided for rental or purchase.
3. Benefits for a multi-user breast pump will be provided without regard to benefits or acquisition of a single-user breast pump.
4. The Company may require a letter of Medical Necessity from a lactation consultant or other Physician before providing benefits for a multi-user pump. The letter all not interfere with the timely acquisition of a multi-user pump.
5. Benefits for rental or purchase of multi-user breast pump shall be made available within 12 hours of notification of need. If the equipment is not available within 12 hours of notification of need, the Company shall reimburse all out-of-pocket rental expenses incurred by the Insured, including any balance billing amounts, until the Insured received the breastfeeding equipment.

Benefits for breastfeeding equipment will include two Breast Pump Kits per birth event, as well as appropriate size breast pump flanges or other lactation accessories recommended by a Physician.

For the purpose of this benefit, “Cost-sharing” means Deductible, Coinsurance, Copayment, or similar charges.

“Breast pump kit” means a collection of tubing, valves, flanges, collection bottles, or other parts required to extract human milk using a breast pump.

“Lactation consultant” means an individual who is an International Board Certified Lactation Consultant.

“Lactation consultation” means the clinical application by a Lactation Consultant or other licensed health care provider of scientific principles and a multidisciplinary body of evidence for evaluation, problem identification, treatment, education, and consultation to child-bearing families utilizing Lactation Care and Services.

“Lactation care and services” will include, but not be limited to:

1. Lactation assessment through the systematic collection of subjective and objective data.
2. Analysis of data and creation of a plan of care.
3. Implementation of a lactation care plan with demonstration and instruction to parents and communication to the primary health care provider.
4. Evaluation of outcomes.
5. Provision of lactation education to parents and health care providers.
6. The recommendation and use of assistive devices.

“Lactation counseling” means breastfeeding education and support services provided by a Lactation Counselor, such as:

1. Educating women, families, health care professionals, and the community about the impact of breastfeeding and human lactation on health and what to expect in the normal course of breastfeeding.
2. Acting as an advocate for breastfeeding as the norm for feeding infants and young children.
3. Providing breastfeeding support, encouragement, and care from preconception to weaning in order to help women and their families meet their breastfeeding goals.
4. Using principles of adult education when teaching clients, health care providers, and others in the community.
5. Identifying and referring high-risk mothers and babies and those requiring clinical treatment appropriately.

“Lactation counselor” means an individual, other than an International Board Certified Lactation Consultant or a licensed health care provider, who is one of the following:

1. Licensed or certified to practice Lactation Counseling under any law, or who is an accredited member belonging to another profession or occupation, who provides breastfeeding education and support services for which that person is licensed, regulated, accredited, or certified.
2. A community-based lactation supporter who has received at least 40 hours of specialty education in breastfeeding and lactation, and who works within a lactation counselor’s scope of practice.

“Telephonic lactation assistance” means Lactation Counseling or consultation with a Lactation Counselor or Lactation Consultant conducted remotely through live voice communication.

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

Section 8: Coordination of Benefits and Services Provision

An Insured may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this Policy as a student and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows the Company to coordinate what the Company pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured is covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

1. **Allowable Expense:** The charge for any health care service, supply or other item of expense for which the Insured is liable when the health care service, supply or other item of expense is covered at least in part by any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

   When this Policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense. The Company will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is a Medical Necessity. When this Policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Company will only consider

corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

2. **Claim Determination Period:** A Policy Year, or portion of a Policy Year, during which an Insured is covered by this Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

3. **Plan:** Coverage with which coordination of benefits is allowed. Plan includes:
   a) group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
   b) self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
   c) group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
   d) group hospital indemnity benefit amounts that exceed $150 per day;
   e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or nongovernmental plan.

   Plan does not include:
   a) individual or family insurance contracts or subscriber contracts;
   b) individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
   c) group or group-type coverage where the cost of coverage is paid solely by the Insured except when coverage is being continued pursuant to a Federal or State continuation law;
   d) group hospital indemnity benefit amounts of $150 per day or less;
   e) school accident-type coverage;
   f) a State plan under Medicaid.

4. **Primary Plan:** The Plan whose benefits for an Insured's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:
   a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
   b) All Plans which cover the Insured use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

5. **Reasonable and Customary:** An amount that is not more than the usual or customary charge for the service or supply as determined by the Company, based on a standard which is most often charged for a given service by a provider within the same geographic area.

6. **Secondary Plan:** The Plan which is not a Primary Plan. If an Insured is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple secondary plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary And Secondary Plan

The Company considers each Plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. The Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the Procedures to be Followed by the Secondary Plan to Calculate Benefits section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for Medically Necessary and appropriate services and supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Rules for the Order of Benefit Determination

(1) The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Insured as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.
(2) The benefits of the Plan that covers the Insured as an employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers the Insured as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.
(3) The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Insured under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.
(4) If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:
    a. The benefits of the Plan of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.
    b. 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.
    c. Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
    d. If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.
(5) If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:
    a. The benefits of the Plan of the parent with custody of the child will pay first;
    b. The benefits of the Plan of the spouse of the parent with the custody of the child will pay second; and
    c. The benefits of the Plan of the parent without custody of the child will pay last.
    d. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

(1) the basis on which the Primary Plan and the Secondary Plan pay benefits; and
(2) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the Insured may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Insured uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the health maintenance organization (HMO) pays the provider a fixed amount per Insured. The Insured is liable only for the applicable deductible, coinsurance or copayment.

If the Insured uses the services of a non-network provider, the HMO will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The secondary plan shall pay the lesser of:

(1) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
(2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

(1) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
(2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the Covered Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Covered Person be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

(1) the difference between the amount of the billed charges for the Allowable Charges and the amount paid by the Primary Plan; or
(2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Insured shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Insured has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the Insured be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
(1) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
(2) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Insured receives services or supplies from a provider who is in the network of both the Primary Plan and the secondary Plan, the Secondary Plan shall pay the lesser of:

(1) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
(2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If the Insured receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Insured shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Right to Receive and Release Needed Information – Certain facts are needed to apply these Coordination of Benefits and Services rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give the Company any facts it needs to pay the claim.

Facility of Payment – A payment made under another plan may include an amount which should have been paid under this Policy. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Policy. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable monetary value of the benefits provided in the form of services.

Right of Recovery – If the amount of the payments made by the Company is more than it should have paid under this provision, it may recover the excess from one or more of: a) the persons it has paid or for whom it has paid; b) insurance companies; or c) other organizations. The "amount of the payments made" includes the reasonable monetary value of any benefits provided in the form of services.

AUTOMOBILE RELATED INJURY BENEFIT PROVISION
(in association with the Coordination of Benefits provision)

Definitions

"Automobile Related Injury" means bodily injury sustained by an Insured Person as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means any Medically Necessary, reasonable, and customary item of expense, a part of which is covered by the Policy or PIP at least in part as an Eligible Expense.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of any Deductible, Copayment or Coinsurance, if any.

"Out-of-State Automobile Insurance Coverage (OSAIC)" means any coverage for medical expenses under an automobile insurance policy other than PIP, as PIP is defined herein, including automobile insurance policies issued in another state or jurisdiction.

"PIP" means Personal Injury Protection coverage (specifically those provisions for medical expense coverage) provided as part of an automobile insurance policy issued in the state of New Jersey.

Application of Benefits

When Covered Medical Expenses are incurred as the result of an Automobile Related Injury, and the injured Insured Person has coverage under PIP or OSAIC, the following sections will be used to determine whether the Policy provides coverage that is primary or secondary to auto coverage. These sections will be also be used to determine the amount payable if the Policy provides primary or secondary coverage.

Determination of Primary or Secondary Coverage

The Policy provides secondary coverage to PIP, unless health coverage has been elected as primary coverage by or for the Insured Person covered under the Policy. This election is made by the named insured under a PIP policy and affects the dependents of the named insured who are not themselves the named insured under another auto policy. The Policy may be primary for one covered person, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC. However, if the OSAIC contains provisions which make it secondary or excess to the Policy, then the Policy will be primary.

Effect on Benefits

If the Policy is primary to PIP or OSAIC, the Policy will pay benefits on eligible expenses in accordance with the terms provided in the Policy.

If the Policy is one of several insurance plans which provide benefits to the Insured and are primary to automobile insurance coverage, then the rules as provided in the Coordination of Benefits provision endorsement shall apply.

If the Named Insured's Policy is secondary to PIP or OSAIC, the benefits payable will be the lesser of: 1) the remaining uncovered allowable expenses after PIP has provided coverage after application of any Deductible or Coinsurance; or 2) the actual benefits that would have been payable had the Named Insured's Policy been providing coverage primary to PIP.

To the extent that the Policy provides coverage that supplements coverage under Medicare, then the Named Insured's Plan can be primary to auto insurance only insofar as Medicare is primary to auto insurance.

Section 9: Definitions

ADOPTED OR FOSTER CHILD means the adopted child or foster child placed with an Insured while that person is covered under the Policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted or foster child not more than 30 days after placement or adoption.

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

Benefits will also be provided for any child placed in court-ordered temporary or other custody of the Insured from the moment of placement.

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 date of placement: 1) apply to us; and 2) pay the required additional premium contribution, 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 date of placement.

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

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

Allowed amounts are based on the following:

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

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

1. **For non-Medical Emergency Covered Medical Expenses received at certain Preferred Provider facilities from Out-of-Network Provider Physicians** when such services are either: a) Ancillary Services; or b) non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* with respect to a visit as defined by Federal guidance, the allowed amount is the lesser of the amount as determined under applicable law or the amount billed by the Out-of-Network Provider.

   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 the lesser of the amount as determined under applicable law or the amount billed by the Out-of-Network Provider.

3. **For Air Ambulance transportation provided by an Out-of-Network Provider**, the allowed amount is the lesser of the amount as determined under applicable law or the amount billed by the Out-of-Network Provider.

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, whether provided by a Physician or non-Physician.
2. Provided by assistant surgeons, hospitalists, and intensivists.
3. Diagnostic services, including radiology and laboratory services.
4. Provided by an Out-of-Network Provider Physician when no other Preferred Provider Physician is available to provide the service at the facility.

CIVIL UNION means the legally recognized union of two eligible individuals of the same sex established pursuant to the Civil Union Act. Parties to a civil union shall receive the same benefits and protections and are subject to the same responsibilities as spouses in a marriage. Civil union includes those same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

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

COMPLICATIONS OF PREGNANCY means: 1) conditions requiring medical treatment prior to or subsequent to termination of pregnancy, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, acute nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) non-elective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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

COPAY/COPAYMENT means the amount that the Insured is required to pay for certain Covered Medical Expenses. A Copay/Copayment may be either a specific dollar amount or a percentage of 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.
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.

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

CUSTODIAL CARE means services that are any of the following:

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

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to the Policy as a deductible, it shall mean 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, Civil Union partner, or Domestic Partner of the Named Insured and dependent children, including any child:

1. For which the Named Insured is under court order to provide coverage.
2. Over whom the Named Insured has legal custody, legal guardianship, or a legal relationship.
3. With whom the Named Insured has a blood relationship, provided the child lives with the Named Insured and is dependent upon the Named Insured for most of his or her support and maintenance.

Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

A dependent child will be eligible to continue coverage after age 26, up to the dependent's 31st birthday, if the dependent meets all of the following:

1. Resides in New Jersey; or if not a resident, is a full-time student at an accredited public or private institution of higher education.
2. Has evidence of creditable coverage or receipt of benefits under a group health plan, a church plan, an individual health benefits plan, or Medicare.
3. Is not covered under another group health plan, church plan, individual health benefits plan, and is not entitled to Medicare as of the effective date of coverage.
4. Does not have any children.
5. Does not have a spouse, Civil Union partner, or Domestic Partner.

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:

a. Incapable of self-sustaining employment by reason of intellectual disability or physical handicap.
b. 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 after the two-year period following the child's attainment of the limiting age. Termination will continue to be waived only while all of the above conditions are met and the Insured continues to be insured under this Policy.

If the Named Insured's insurance under this policy terminates due to that person's death, insurance then in force on such Named Insured's Dependents will be continued for 180 days. This continuation of coverage is subject to the timely payment of the premium contribution due for the Insured Dependent's insurance and this Policy provisions with respect to termination for reasons other than death of the Insured.

DOMESTIC PARTNER means a person who is not related by blood or marriage to the Named Insured but who:
1. Is, along with the Named Insured, 62 years or older, regardless of gender.
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 basic living expenses.

4. Is not in a marriage recognized by New Jersey law or a member of another domestic partnership.
5. Has chosen with the Named Insured to share each other's lives in a committed relationship of mutual caring.
6. Filed with the Named Insured an Affidavit of Domestic Partnership.
7. Has not been in a domestic partnership that was terminated less than 180 days prior to the filing of a current Affidavit of Domestic Partnership; this prohibition will not apply if the prior partner died.

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

1. A joint deed, 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, banking 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.

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

a. 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.
b. To the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, services 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 determined by the emergency Physician or the treating provider, 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 specified by federal guidance.

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

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

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

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

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

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 to an Insured Person which is all of the following:

a. Caused by an accident which occurs while this Policy is in force as to that Insured Person.
b. Treated by a Physician within 30 days after the date of accident.
c. Which, directly and independently of all other causes, results in loss covered by this Policy.

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 contribution 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 (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances, and /or symptoms of Substance Use Disorder, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention would result in any of the following:

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

With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another Hospital before deliver or the transfer may pose a threat to the health or safety of the woman or the 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 or describes those health care services that a health care provider or facility, including but not limited to a Hospital or Physician, exercising prudent clinical judgment, would provide to an Insured Person, which are all of the following:

1. For the purpose of evaluating, diagnosing, or treating a Sickness or Injury, or its symptoms.
2. Is provided in accordance with the generally accepted standards of medical practice.
3. Is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Insured Person’s Injury or Sickness.
4. Is not primarily for the convenience of the Insured Person or the Physician.
5. Is not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Insured Person’s Injury or Sickness.

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

MENTAL HEALTH CONDITION means a mental health condition defined to be consistent with generally recognized independent standards of current medical practice referenced by the American Psychiatric Association in the current version of the Diagnostic and Statistical Manual of Mental Disorders. If not excluded or defined elsewhere in the Policy, all related mental health or psychiatric diagnoses and recurrent symptoms of the same or a similar condition not separated by more than six months after a return to normal activity 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 contribution for coverage has been paid.

NEWBORN INFANT means any child born of an Insured while that person is insured under the Policy. Newborn Infants will be covered under the Policy for the first 60 days after birth on the same basis as any other Dependent children. Benefits for such a child will be for Injury or Sickness and paid on the same basis as any other Injury or Sickness, including medically diagnosed Congenital Conditions and birth abnormalities.

The Insured will have the right to continue such coverage for the child beyond the first 60 days. To continue the coverage the Insured must, within the 60 days after the child's birth: 1) apply to the Company; and 2) pay the required additional premium contribution, 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 60 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.

OTHER VALID AND COLLECTIBLE GROUP INSURANCE means: 1) any group plan, program or insurance policy; 2) any other group hospital, surgical or medical benefit plan; 3) union welfare plans; or 4) group employer or employee benefit programs.

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. All Covered Medical Expenses paid as Copayment, Coinsurance, or Deductible shall count toward the Out-of-Pocket Maximum. Refer to the Schedule of Benefits for details on how the out-of-pocket maximum applies.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person’s immediate family.

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

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

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

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

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

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

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

PRESCRIPTION DRUGS mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs including "off-label" use of Food and Drug Administration ("FDA") approved drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

Prescription Drugs also means a drug prescribed for treatment which has not been approved by the FDA, however, the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in the: 1) American Hospital Formulary Service Drug Information; 2) United States Pharmacopeia Drug Information; or is recommended by a clinical study or review article in a major peer-reviewed professional journal.

Prescription Drugs does not mean any experimental or investigational drug; or any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

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, including a Mental Health Condition or Substance Use Disorder, 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 not separated by more than six months after a return to normal activity 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 which are present.

SUBSTANCE USE DISORDER means a disorder defined to be consistent with generally recognized independent standards of current medical practice referenced in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. If not excluded or defined elsewhere in the Policy, all alcoholism and substance use disorders and recurrent symptoms of the same or a similar condition not separated by more than six months after a return to normal activity will be considered one Sickness.

TELEHEALTH/TELEMEDICINE means live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as an Insured Person's home or place of work.

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

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

Section 10: 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. Acupuncture, except as specifically provided in the Policy.
2. Behavioral problems. Developmental delay or disorder or intellectual disability. Learning disabilities.
   This exclusion does not apply to benefits specifically provided in Mental Health Condition and Substance Use Disorder Treatment.
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.
   - Treat or correct a functional defect caused by a Congenital Condition.
4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or Substance Use Disorder facilities for domiciliary or Custodial Care.
5. Dental treatment, except as described in 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, except for the removal of nail roots, and bunions.

   This exclusion does not apply to Medically Necessary open surgery of the foot or to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
9. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

- Hearing defects or hearing loss as a result of an infection or Injury.
- Benefits specifically provided in the Policy.

10. Hirsutism. Alopecia.
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
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. Lipectomy.
14. Participation in a riot or civil disorder. Loss to which a contributing cause was the Insured Person's commission of or attempt to commit a felony or engagement in an illegal occupation.
15. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
    - Immunization agents, except as specifically provided in the Policy.
    - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for a drug for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia: (1) the American Hospital Formulary Service Drug Information; (2) the United States Pharmacopeia Drug Information; or it is recommended by a clinical study or review article in a major peer-reviewed professional journal. Any coverage of a drug shall also include Medically Necessary services associated with the administration of the drug.
    - Products used for cosmetic purposes, except as specifically provided in the Policy.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Sexual enhancement drugs.
    - Refills in excess of the number specified or dispensed after one year of date of the prescription.
16. Reproductive services for the following:
    - Procreative counseling.
    - Genetic counseling and genetic testing.
    - Cryopreservation of reproductive materials. Storage of reproductive materials.
    - Premarital examinations.
    - Impotence, organic or otherwise.
    - Female sterilization procedures, except as specifically provided in the Policy.
    - Vasectomy, except as specifically provided in the Policy.
    - Reversal of sterilization procedures.

    This exclusion does not apply to benefits specifically provided for in Benefits for Infertility Treatment, Benefits for Fertility Preservation Services, or Benefits for Contraceptive Services and Devices.
17. 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.
18. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

    This exclusion does not apply as follows:
    - When due to a covered Injury or disease process.
    - To benefits specifically provided in Pediatric Vision Services.
    - To one pair of eyeglasses or contact lenses for the initial replacement for the loss of a natural lens.
19. Services provided normally without charge.
20. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
21. 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.
22. Supplies, except as specifically provided in the Policy.
23. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.

24. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
25. War or any act of war, declared or undeclared, while the Insured Person:
    - Is serving in the armed forces of any country.
    - Is serving in any civilian non-combatant unit supporting or accompanying any armed forces of any country or international organization.
    - Is not serving in any armed forces if the Injury or Sickness occurs outside the 50 states of the United States of America, the District of Columbia, or Canada.

    A pro-rata premium contribution will be refunded upon request for such period not covered.
26. Weight management. Weight reduction. Nutrition programs, except for prescribed nutritional counseling for the management of a disease which has a specific diagnostic criteria that can be verified. Treatment for obesity (except morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Benefits for Treatment of Inherited Metabolic Disease or as specifically provided in the Policy.

Section 11: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment, or when not in school, to their Physician or Hospital.
2. Insureds can submit claims online in their My Account at www.uhcsr.com/MyAccount or submit claims by mail. If submitting by mail, send to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured’s insurance Company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Claims submitted by the Insured should be submitted 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.
4. Claims submitted on behalf of the Insured by a health care professional should be submitted within 60 days for the last date of service for a course of treatment.

    If the Insured has assigned benefits to a health care professional, then a claim for payment should be submitted by the health care professional within 180 days of the last date of service for a course of treatment. If the professional does not file the claim within 180 days of the last date of service for a course of treatment, the Company shall reserve the right to deny payment of the claim, in accordance with regulations established by the Commissioner of Banking and Insurance and the professional shall be prohibited from seeking reimbursement directly from the Insured.

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

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

Section 12: General Provisions

GRACE PERIOD: A grace period of 31 days will be provided for the payment of each premium contribution due after the first premium contribution. The Insured Person’s premium contribution 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 contribution payment is made.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Any notice given by or on behalf of the Insured Person or beneficiary to the Company at P.O. Box 809025, Dallas, Texas 75380-9025 or to any of our authorized agents, with information sufficient to identify the Insured Person shall be deemed notice to the Company.

CLAIM FORMS: A Company claim form is not required for filing a claim. All medial and Hospital bills, along with the name of the Insured patient, the Named Insured’s address, SRID number, and name of the Policyholder should be mailed to the Company at P.O. Box 809025, Dallas, Texas 75380-9025. For Out-of-Network Provider and Out-of-Network Pharmacy claims, an Insured should submit a claim to the Company for the total amount the Insured paid minus any applicable Copayment.

PROOF OF LOSS: Written proof of loss must be furnished by the Insured to the Insurer at P. O. Box 809025, Dallas, Texas 75380-8925 within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give written proof in the time required. In no event, except in the absence of legal capacity, shall written proof of loss be furnished later than one year from the time proof is otherwise required.

HEALTH CARE PROFESSIONAL'S CLAIM FILING: A health care professional licensed pursuant to Title 45 of the New Jersey Revised Statutes is responsible for filing claims for third party payment, including claims filed on behalf of the licensed professional's patient for any health care service provided by the licensed professional that is eligible for third party payment. The Insured may, at his or her option, file the third party payment claim themselves.

In the case of a claim filed on behalf of the Insured, the professional shall file the claim within 60 days of the last date of services for a course of treatment.

In the case of a claim in which the Insured has assigned benefits to the professional, the professional shall file the claim within 180 days of the last date of services for a course of treatment. If the professional does not file the claim within 180 days of the last date of service for a course of treatment, the Company shall reserve the right to deny payment of the claim, in accordance with regulations established by the Commissioner of Banking and Insurance and the professional shall be prohibited from seeking reimbursement directly from the Insured.

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid upon receipt of due written proof of such loss. Eligible claims submitted electronically will be paid on the earlier of: a) the 30th calendar day following receipt of the claim; or b) the time limit established by Medicare pursuant to 42 U.S.C. s. 1395u(c)(2)(B). For eligible claims submitted by other than electronic means, payment will be made no later than the 40th calendar day following receipt of the claim.

The claim payment will be made on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means following receipt by the Company of the required documentation or modification of an initial submission. The Company will, within 30 or 40 calendar days, whichever is applicable, provide a notice of the basis of its decision to deny or dispute the claim. This notice shall be sent to the Insured when the Insured has an increased responsibility for payment and the provider of the services.

If the claim is incomplete, the notice shall include a statement identifying the substantiating documentation or other information that is required for adjudication of the claim. If the diagnosis coding, procedure coding, or any other required information is incorrect, the notice shall include a statement identifying the information that must be corrected for adjudication of the claim. If the Company disputes the amount of the claim, in whole or in part, the notice shall include a statement of the basis for that dispute, including any change of coding performed by the Company and the reasons for such coding change.

If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding, or any other required data is missing, the Company shall electronically notify the provider of the services within seven days of its determination that the claim is missing required information. This notice shall include a request for any information required to complete the adjudication of the claim.

If the Company finds there is strong evidence of fraud by the provider of services and has initiated an investigation into the suspected fraud, the notice shall state the Company finds that there is strong evidence of fraud and, if applicable, that an investigation has been initiated in accordance with the Company's fraud prevention plan and that the claim, along with supporting documentation, has been referred to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety and the Bureau of Fraud Deterrence in the Department of Insurance.

The Company shall pay the amount finally agreed upon in settlement of all or part of any claim no later than 10 working days from either the receipt of such agreement by the Company or the date the Insured Person or Provider meets any conditions to payment set forth in the agreement, whichever is later.

The Company shall not deny, delay or pend payment of a claim, in whole or in part, while seeking information as to whether the Insured has other insurance coverage, unless good cause exists for the Company to believe that the Insured has other coverage. Good cause shall exist only if the Company's records indicate that the Insured has coverage under another health benefit or prescription drug plan. Routine requests to determine whether additional coverage exists shall not be considered good cause.

All overdue payments shall bear simple interest at the rate of 12% per annum.

PAYMENT OF CLAIMS: All benefits are payable to the Insured. If the Insured is a minor, such benefits may be made payable to his or her parent, guardian or other person chiefly supporting him or her. A loss of life benefit, if any, will be paid in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, that benefit shall be paid to the estate of the Insured Person. Any other benefits unpaid at the death of the Insured Person may, at our option, be paid to the beneficiary (other than the Policyholder or an officer of the Policyholder as such) or the Insured Person's estate. Subject to any written direction of the Insured, all or a portion of any benefits payable under the Policy may be paid directly to the Hospital, Physician or person rendering the service or treatment.

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 made by us in good faith pursuant to this provision shall fully discharge us to the extent of such payment.

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

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

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and Coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made. Except for claims submitted fraudulently or submitted by health care providers with a pattern of inappropriate billing or applicable claims subject to coordination of benefits or excess provision, the Company will not seek reimbursement for overpayment of a claim after 18 months from the date of the first payment on the claim.

The Company will not collect or attempt to collect:

1. The funds for the reimbursement on or before the 45th day following submission of a reimbursement request to the provider of services.
2. The funds for the reimbursement if the health care provider disputes the request and initiates an appeal on or before the 45th day following the submission of the reimbursement request to the provider of services and until the provider's rights to appeal are exhausted.
3. A monetary penalty against the reimbursement request, including, but not limited to, an interest charge or a late fee.

The Company may offset an overpayment made to a provider against that provider's future insured claims if the Company has issued a reimbursement request and only if:

1. The offset action applies to claims submitted by the provider after the 45th calendar day following submission of a reimbursement request.
2. The Company submits to the provider a detailed written offset notice so the provider may reconcile the bills of each Insured Person subject to the offset action.
3. The provider does not initiate an appeal of the reimbursement request within 45 calendar days.
4. The provider is given 30 days after receipt of the offset notice to reimburse the Company for the overpayment.

The provider may contest a reimbursement request through the internal and external appeal processes outlined in the Notice of Appeal Rights section of this Certificate.

REIMBURSEMENT OF UNDERPAID CLAIMS: No provider shall request reimbursement from the Company or from an Insured Person later than 18 months from the date the first payment was made on a claim unless the claim is the subject of an internal appeal or is subject to continual claim submission. A provider shall not seek more than one reimbursement for underpayment of any particular claim from the Company or the Insured Person.

The provider's written reimbursement request shall be a separate notice to the Company or the Insured Person and shall include:

1. A clear identification of the claim.
2. The name of the Insured Person and the date of service.
3. An explanation of the basis upon which the provider believes the amount paid was less than the amount due.

CONTINUATION OF COVERAGE: Named Insureds who have been continuously insured under the Policy for three months and due to their Total Disability are no longer eligible for coverage shall be entitled to continue coverage for themselves and their covered Dependents. This continued coverage shall terminate at the first to occur of the following: 1) failure to make timely premium contribution payment; 2) the date the Named Insured becomes eligible under another group plan providing similar benefits; 3) the date the Policy terminates. The premium rate for the continued coverage will be the same premium rate charged to other Insureds who are eligible for coverage under the Policy.

Section 13: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

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

The written Internal Appeal request should include:

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

Please contact the Customer Service Department at 1-866-599-4427 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare Student Resources, P.O. Box 809025, Dallas, TX 75380-9025.

Internal Appeal Process
Within 180 days after receipt of a notice of an Adverse Determination, an Insured Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination, except where the Adverse Determination is based on eligibility, including rescission, or on the application of a contract exclusion or limitation not relating to Medical Necessity.

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

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

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

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide:

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

The new or additional information shall be provided free of charge to the Insured Person or Authorized Representative and as soon as possible and sufficiently in advance of the date on which the final Internal Review is required to be provided in order to allow the Insured Person or Authorized Representative adequate opportunity to respond to any new or additional evidence or rationale.

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

1. For a Pre-service Claim review, the notice shall be made no later than 15 days after the Company's receipt of the grievance.
2. For a Post-service Claim review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.

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

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

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
   a. The date of service;
   b. The name health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
   d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
   e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
   f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an Independent Health Care Appeal of the Final Adverse Determination with the state's Independent Health Care Appeals Program and the form required to initiate such appeal; and
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
7. Notice of the Insured Person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time. The Insured may also contact the Department of Banking and Insurance at the following address: Office of the Insurance Ombudsman, P. O. Box 472, Trenton, New Jersey 08625-0472. Phone Number (800) 446-7467.

Benefits shall continue to be provided for an ongoing course of treatment pending the outcome of the appeal.

Expedited Internal Review

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

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

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

To request an Expedited Internal Appeal, please contact Claims Appeals at 1-888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare Student Resources, P.O. Box 809025, Dallas, TX 75380-9025.

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

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

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

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

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file a request for an Independent Health Care Appeal if:

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

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

Benefits shall continue to be provided for an ongoing course of treatment pending the outcome of the appeal.

RIGHT TO INDEPENDENT HEALTH CARE APPEAL
After exhausting the Company's Internal Appeal process, an Insured Person or Authorized Representative may submit a request for an Independent Health Care Appeal when the service or treatment in question:

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has four months to request an Independent Health Care Appeal. The request for an Independent Health Care Appeal should be made in writing to the Commissioner on forms provided to the Insured Person at the completion of the Internal Review Process.

The request for an Independent Health Care Appeal should be accompanied by $25 filing fee, payable by check or money order to the New Jersey Department of Banking and Insurance. The fee shall be waived if a financial hardship exists. Financial hardship may be demonstrated by the Insured Person through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance. The filing fees for any one Insured Person shall not exceed $75.00 per policy year.

If the External Appeal Agent overturns the Adverse Determination or Final Adverse Determination, then the Company shall refund the fee.

Benefits shall continue to be provided for an ongoing course of treatment pending the outcome of the appeal.

Where to Send Independent Health Care Appeal Requests
All types of Independent Health Care Appeal requests shall be submitted to the New Jersey Department of Banking and Insurance at the following address:

Office of the Insurance Ombudsman
New Jersey Department of Banking and Insurance
20 West State Street
P. O. Box 472
Trenton, NJ 08625-0472
(888) 393-1062 (appeals)
http://www.state.nj.us/dobi/consumer.htm
ombudsman@dobi.nj.gov

Independent Health Care Appeal Process
The New Jersey Department of Banking and Insurance shall forward the appeal to an IURO.

Upon receipt of the appeal, the IURO shall conduct a preliminary review and accept the request if:

a. The individual was an Insured Person covered under the Policy at the time the service was requested or provided;
b. The Insured Person has provided all the information and forms required by the IURO and the Department to make a preliminary determination; and
c. The service in question reasonably appears to be a Covered Medical Expense under the Policy.

Immediately after completion of the preliminary review, the IURO shall notify the Insured Person and, if applicable, the Authorized Representative in writing whether the request has been accepted. If the request is not complete, the IURO's notice shall include the reason(s) why the request is incomplete.

The IURO shall also notify the Insured Person and, if applicable, the Authorized Representative of the right to submit additional written information to be considered in the IURO's review. The IURO shall provide the Company with copies of any such additional information within one business day after receipt.

The IURO shall complete its review in a manner consistent with New Jersey state requirements. The IURO's final decisions shall be provided to the Insured Person, the Company, the Authorized Representative (if any), and the Department. The IURO's determination shall be binding on the Company and the Insured Person, except to the extent that other remedies are available under State or Federal law.

Within 10 business days of receiving the IURO's determination, the Company shall provide benefits (including authorization of a service or supply and payment of the claim) pursuant to the IURO's determination, regardless of whether the Company intends to seek judicial review of the determination, unless there is a judicial decision stating otherwise.

The Company shall provide benefits to comply with the IURO's determination sooner if the medical exigencies of the case warrant a more rapid response.

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

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

Authorized Representative means:

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

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

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

IURO means an Independent Utilization Review Organization.

Out-of-Network Exception means a request by an Insured or a Physician to obtain Medically Necessary covered services from an Out-of-Network Provider, with the Insured's liability being limited to the Preferred Provider level of cost sharing. An Out-of-Network Exception may only be requested when the Company's network does not have a Preferred Provider who is qualified, accessible, and available to perform the Insured's required Medically Necessary service**.**

Post-service Claim means any claim for a benefit that is not a Pre-service Claim.

Pre-service Claim means any claim for a benefit to which the terms of the plan condition receipt of the benefit, in accordance with the Company's requirement that the service be approved, in whole or in part, prior to its provision.

Urgent Care Claim means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care claim determination, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine:

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

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Pre-service Claim review, second opinion, certification, concurrent review, case management, discharge planning, or Post-service Claim review.

Questions Regarding Appeal Rights

Contact Customer Service at 1-866-599-4427 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

The Office of the Insurance Ombudsman
New Jersey Department of Banking and Insurance
20 West State Street
P. O. Box 472
Trenton, NJ 08625-0472
(800) 446-7467
(888) 393-1062 (appeals)
http://www.state.nj.us/dobi/consumer.htm
ombudsman@dobi.nj.gov

Section 14: 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 15: 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 16: UHCSR Mobile App

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

- ID Cards – view, save to your device, fax or email directly to your provider. 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 17: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare Student Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-866-599-4427
Website: www.uhcsr.com

Schedule of Benefits

Rutgers Post Doctorate, Grad Fellows, Teaching and Grad Assistants

2023-202826-1

METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 91.0360%

Injury and Sickness Benefits

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

Deductible Preferred Provider	$100 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	90% except as noted below
Coinsurance Out-of-Network Provider	60% except as noted below
Out-of-Pocket Maximum Preferred Provider	$2,500 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$5,000 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$10,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$20,000 (For all Insureds in a Family, Per Policy Year)

The Preferred Provider Deductible or Coinsurance will not apply to any Preventive Care benefits provided under the Policy.

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

The **Preferred Provider** for this plan is UnitedHealthcare Choice Plus.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If the Policy includes both a Preferred Provider Coinsurance amount and a Preferred Provider Copayment amount, then the Preferred Provider Coinsurance amount will not be applied to those benefits that include a Preferred Provider Copayment amount. If the Policy includes both a Preferred Provider Coinsurance amount and a Preferred Provider Copayment amount, then the Preferred Provider Copayment amount will not be applied to those benefits that include a Preferred Provider Coinsurance amount.

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.

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

Student Health Center Benefits: The Deductible and 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.

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

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Room and Board Expense	Allowed Amount after Deductible	Allowed Amount after Deductible

Inpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Intensive Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Miscellaneous Expenses	Allowed Amount after Deductible	Allowed Amount after Deductible
Routine Newborn Care See Benefits for Postpartum Care and Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Registered Nurse's Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	100% of Allowed Amount after Deductible	Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission.	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible
Day Surgery Miscellaneous	Allowed Amount after Deductible	Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Allowed Amount after Deductible	Allowed Amount after Deductible

Outpatient	Preferred Provider Benefits	Out-of-Network Provider Benefits
Anesthetist Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Physician's Visits	$35 Copay per visit 100% of Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Audiology and Speech Language Pathology	Allowed Amount after Deductible	Allowed Amount after Deductible
Medical Emergency Expenses	Allowed Amount after Deductible	90% of Allowed Amount after Deductible (The Insured's total out-of-pocket will not exceed the amount the Insured would have paid to a Preferred Provider.)
Diagnostic X-ray Services	Allowed Amount after Deductible	Allowed Amount after Deductible
Radiation Therapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Laboratory Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Tests & Procedures	Allowed Amount after Deductible	Allowed Amount after Deductible
Injections	Allowed Amount after Deductible	Allowed Amount after Deductible
Chemotherapy	Allowed Amount after Deductible	Allowed Amount after Deductible
Prescription Drugs *See UHCP Prescription Drug Benefit Endorsement for additional information.	*UnitedHealthcare Pharmacy (UHCP) Retail Network Pharmacy $15 Copay per prescription Tier 1 $30 Copay per prescription Tier 2 $50 Copay per prescription Tier 3 up to a 31-day supply per prescription not subject to Deductible **Please note:** Generic drugs, brand-name drugs and specialty prescription drugs may appear in any tier of the Prescription Drug List (PDL). If a generic drug is in any tier other than Tier 1, the Copay will be $25 per 31-day supply rather than the specified tier Copay. Refer to the PDL to determine which tier your prescription drug has been assigned. UHCP Mail Order Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply. If a retail UnitedHealthcare Network Pharmacy agrees to the same rates, terms and requirements associated with dispensing a 90-day supply, then up to a consecutive 90-day supply of a Prescription Drug at 2.5 times the Copay that applies to a 31-day supply per prescription.	60% of billed charge up to a 31-day supply per prescription not subject to Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Ambulance Services	Allowed Amount after Deductible	90% of Allowed Amount after Deductible
Durable Medical Equipment See also Benefits for Orthotic and Prosthetic Appliances	Allowed Amount after Deductible	Allowed Amount after Deductible
Consultant Physician Fees	$25 Copay per visit 100% of Allowed Amount not subject to Deductible	Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth and for surgical removal of bony, impacted teeth only.	Allowed Amount after Deductible	90% of Allowed Amount after Deductible
Mental Health Condition and Substance Use Disorder Treatment	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** $35 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible	**Inpatient:** Allowed Amount after Deductible **Outpatient office visits:** Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** Allowed Amount after Deductible
Maternity See Benefits for Postpartum Care and Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	Allowed Amount after Deductible	Allowed Amount after Deductible
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Allowed Amount	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Breast Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes Treatment	Paid as any other Sickness	Paid as any other Sickness
Home Health Care See Benefits for Home Health Care	Paid as any other Sickness or Injury	Paid as any other Sickness or Injury
Hospice Care	Allowed Amount after Deductible	Allowed Amount after Deductible
Inpatient Rehabilitation Facility	Allowed Amount after Deductible	Allowed Amount after Deductible

Other	Preferred Provider Benefits	Out-of-Network Provider Benefits
Skilled Nursing Facility	Allowed Amount after Deductible	Allowed Amount after Deductible
Urgent Care Center	Allowed Amount after Deductible	Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	Allowed Amount after Deductible	Allowed Amount after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See endorsements attached for Pediatric Dental and Vision Services benefits	See endorsements attached for Pediatric Dental and Vision Services benefits
Acupuncture in Lieu of Anesthesia	Paid as any other Sickness	Paid as any other Sickness
Ostomy Supplies	Allowed Amount after Deductible	Allowed Amount after Deductible

Refer to Section 7 of the Certificate of Coverage for the following Mandated Benefits:
Benefits for Diabetes Treatment
Benefits for Treatment of Inherited Metabolic Disease
Benefits for Inpatient Coverage for Mastectomies
Benefits for Reconstructive Breast Surgery
Benefits for Mammography
Benefits for Digital Tomosynthesis of the Breast
Benefits for Prostate Cancer Testing (PSA)
Benefits for Colorectal Cancer Screening
Benefits for Treatment of Wilm's Tumor
Benefits for Audiology and Speech Language Pathology
Benefits for Pap Smear
Benefits for Home Health Care
Benefits for Anesthesia and Hospitalization for Dental Services
Benefits for Infertility Treatment
Benefits for Fertility Preservation Services
Benefits for Orthotic and Prosthetic Appliances
Benefits for Hearing Aids
Benefits for Contraceptive Services and Devices
Benefits for Non-Standard Infant Formulas
Benefits for Donated Human Breast Milk
Benefits for Lead Poisoning Screening, Newborn Hearing Loss and Childhood Immunizations
Benefits for Postpartum Care and Routine Newborn Care
Benefits for Oral Chemotherapy Drugs
Benefits for Treatment of Sickle Cell Anemia
Benefits for Prescription Eye Drops
Benefits for Medication Synchronization
Benefits for Breastfeeding Support

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

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.

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 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 Dental Services and Dental Procedures, except when provided for a Dental Emergency. 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.

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.

Benefits

Subject to the applicable Deductible, Coinsurance, or Copayments shown on the Schedule of Benefits, Benefits will be provided for diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services as described in this endorsement for Insured Persons under the age of 19 when services are provided by a Dental Provider.

1. Dental services are available from birth with an age one dental visit encouraged.
2. A second opinion is allowed.
3. Dental Emergency treatment is available without prior authorization. Dental Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.

4. Diagnostic and preventive services are linked to the Dental Provider, thus allowing an Insured Person to transfer to a different Dental Provider and receive these services. The new Dental Provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
5. Denials of services to the Dental Provider shall include an explanation and identify the reviewer including their contact information.
6. Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
7. Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
8. Services that are considered Experimental, Investigational, or Unproven in nature will not be considered.
9. This endorsement will not cover any charges for broken appointments.

Diagnostic Services

* Indicates diagnostic services that can be considered every 3 months for Insureds with special healthcare needs.

1. Clinical oral evaluations once every 6 months *
    - Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
    - Periodic oral evaluation – subsequent thorough evaluation of an established insured patient*
    - Oral evaluation for an Insured under the age of 3 and counseling with primary caregiver*
    - Limited oral evaluations that are problem focused
    - Detailed oral evaluations that are problem focused
2. Diagnostic imaging with interpretation
    - A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
    - An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
    - Additional films/views needed for diagnosing can be provided as needed.
    - Bitewings, periapicals, panoramic and cephlometric radiographic images
    - Intraoral and extraoral radiographic images
    - Oral/facial photographic images
    - Maxillofacial MRI, ultrasound
    - Cone beam image capture
3. Tests and Examinations
4. Viral culture
5. Collection and preparation of saliva sample for laboratory diagnostic testing
6. Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
7. Oral pathology laboratory
    - Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
    - Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
    - Other oral pathology procedures, by report

Preventive Services

* Indicates preventive services that can be considered every 3 months for Insureds.

1. Dental prophylaxis once every 6 months*
2. Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*
3. Fluoride varnish once every 3 months for Insured Dependents under the age of 6
4. Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars. Replacement of sealants can be considered with prior authorization.
5. Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal
    - fixed – unilateral and bilateral
    - removable – bilateral only
    - recementation of fixed space maintainer
    - removal of fixed space maintainer – considered for provider that did not place appliance

Restorative Services

1. There are no frequency limits on replacing restorations (fillings) or crowns.
2. Request for replacement due to failure soon after insertion, may require documentation to demonstrate material failure as the cause.

3. Reimbursement will include the restorative material and all associated materials Necessary to provide the standard of care, polishing of restoration, and local anesthesia.
4. The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
5. Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
6. Reimbursement for an occlusal restoration includes any extensions onto the occlusal one-third of the buccal, facial or lingual surface(s) of the tooth.
7. Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:
1. Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
2. Gold foil - Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
3. Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
4. Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
   - Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
   - Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
   - Provisional crowns are not covered.
5. Recement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
6. Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
7. Core buildup including pins
8. Pin retention
9. Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
10. Additional fabricated (custom fabricated/cast) and prefabricated post
11. Post removal
12. Temporary crown (fractured tooth)
13. Additional procedures to construct new crown under existing partial denture
14. Coping
15. Crown repair
16. Protective restoration/sedative filling

Endodontic Services
1. Service includes all Necessary radiographs or views needed for endodontic treatment.
2. Teeth must be in occlusion, periodontally sound, needed for function and have good long term prognosis.
3. Emergency services for pain do not require prior authorization.
4. Service requires prior authorization and will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:
1. Therapeutic pulpotomy for primary and permanent teeth
2. Pulpal debridement for primary and permanent teeth
3. Partial pulpotomy for apexogensis
4. Pulpal therapy for anterior and posterior primary teeth
5. Endodontic therapy and retreatment
6. Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
7. Apexification: initial, interim and final visits
8. Pulpal regeneration
9. Apicoectomy/Periradicular Surgery
10. Retrograde filling
11. Root amputation
12. Surgical procedure for isolation of tooth with rubber dam

13. Hemisection
14. Canal preparation and fitting of preformed dowel or post
15. Post removal

Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

1. Surgical services
    - Gingivectomy and gingivoplasty
    - Gingival flap including root planning
    - Apically positioned flap
    - Clinical crown lengthening
    - Osseous surgery
    - Bone replacement graft – first site and additional sites
    - Biologic materials to aid soft and osseous tissue regeneration
    - Guided tissue regeneration
    - Surgical revision
    - Pedicle and free soft tissue graft
    - Subepithelial connective tissue graft
    - Distal or proximal wedge
    - Soft tissue allograft
    - Combined connective tissue and double pedicle graft
2. Non-Surgical Periodontal Service
    - Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
    - Periodontal root planing and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
    - Full mouth debridement to enable comprehensive evaluation
    - Localized delivery of antimicrobial agents
3. Periodontal maintenance

Prosthodontic Services

1. All dentures, fixed prosthodontics (fixed bridges) and maxillofacial prosthetics require prior authorization.
2. New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
3. All needed dental treatment must be completed prior to denture fabrication.
4. Patient identification must be placed in dentures in accordance with State Board regulation.
5. Insertion of dentures includes adjustments for 6 months post insertion.
6. Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

1. Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
2. Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
    - Resin base and cast frame dentures including any conventional clasps, rests and teeth
    - Flexible base denture including any clasps, rests and teeth
    - Removable unilateral partial dentures or dentures without clasps are not considered
3. Overdenture – complete and partial
4. Denture adjustments –6 months after insertion or repair
5. Denture repairs – includes adjustments for first 6 months following service
6. Denture rebase – following 12 months post denture insertion and subject to prior authorization denture rebase is covered and includes adjustments for first 6 months following service
7. Denture relines – following 12 months post denture insertion denture relines are covered once a year without prior authorization and includes adjustments for first 6 months following service
8. Precision attachment, by report
9. Maxillofacial prosthetics - includes adjustments for first 6 months following service
    - Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement
    - Obturator prosthesis: surgical, definitive and modifications
    - Mandibular resection prosthesis with and without guide flange

- Feeding aid
- Surgical stents
- Radiation carrier
- Fluoride gel carrier
- Commissure splint
- Surgical splint
- Topical medicament carrier
- Adjustments, modification and repair to a maxillofacial prosthesis
- Maintenance and cleaning of maxillofacial prosthesis

10. Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years.
    Covered services include: implant body, abutment and crown.
11. Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists.
    - The replacement of an existing defective fixed bridge is also allowed when noted criteria are met.
    - A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge.
    - Considerations and requirements noted for single crowns apply
    - Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth.
    - Abutment teeth must be periodontally sound and have a good long term prognosis
    - Repair and recementation
12. Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

1. Extraction of teeth:
    - Extraction of coronal remnants – deciduous tooth,
    - Extraction, erupted tooth or exposed root
    - Surgical removal of erupted tooth or residual root
    - Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications
2. Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
3. Other surgical Procedures
    - Oroantral fistula
    - Primary closure of sinus perforation and sinus repairs
    - Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident
    - Surgical access of an unerupted tooth
    - Mobilization of erupted or malpositioned tooth to aid eruption
    - Placement of device to aid eruption
    - Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy
    - Surgical repositioning of tooth/teeth
    - Transseptal fiberotomy/supra crestal fiberotomy
    - Surgical placement of anchorage device with or without flap
    - Harvesting bone for use in graft(s)
4. Alveoloplasty in conjunction or not in conjunction with extractions
5. Vestibuloplasty
6. Excision of benign and malignant tumors/lesions
7. Removal of cysts (odontogenic and nonodontogenic) and foreign bodies
8. Destruction of lesions by electrosurgery
9. Removal of lateral exostosis, torus palatinus or torus madibularis
10. Surgical reduction of osseous tuberosity
11. Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
12. Surgical Incision
    - Incision and drainage of abcess - intraoral and extraoral

- Removal of foreign body
- Partial ostectomy/sequestrectomy
- Maxillary sinusotomy

13. Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
14. Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
    - Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider.
    - Manipulation under anesthesia
    - Condylectomy, discectomy, synovectomy
    - Joint reconstruction
    - Services associated with TMJD treatment require prior authorization
15. Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage
16. Arthroscopy
17. Occlusal orthotic device – includes placement and removal to same provider
18. Surgical and other repairs
    - Repair of traumatic wounds – small and complicated
    - Skin and bone graft and synthetic graft
    - Collection and application of autologous blood concentrate
    - Osteoplasty and osteotomy
    - LeFort I, II, III with or without bone graft
    - Graft of the mandible or maxilla – autogenous or nonautogenous
    - Sinus augmentations
    - Repair of maxillofacial soft and hard tissue defects
    - Frenectomy and frenoplasty
    - Excision of hyperplastic tissue and pericoronal gingiva
    - Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
    - Emergency tracheotomy
    - Coronoidectomy
    - Implant – mandibular augmentation purposes
    - Appliance removal – “by report” for provider that did not place appliance, splint or hardware

Orthodontic Services

Medical Necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

1. Orthodontic treatment requires prior authorization and is not considered for cosmetic purposes.
2. Orthodontic consultation can be provided once annually as needed by the same provider.
3. Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
4. Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
5. Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to the Insured’s 19th birthday.
6. Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
7. The placement of the appliance represents the treatment start date.
8. Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case and requires prior authorization.
9. Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

1. Limited treatment for the primary, transitional and adult dentition
2. Interceptive treatment for the primary and transitional dentition

3. Minor treatment to control harmful habits
4. Continuation of transfer cases or cases started outside of the program
5. Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate Medical Necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented Medical Necessity.
6. Orthognathic Surgical Cases with comprehensive orthodontic treatment
7. Repairs to orthodontic appliances
8. Replacement of lost or broken retainer
9. Rebonding or recementing of brackets and/or bands

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

1. Palliative treatment for emergency treatment – per visit
2. Anesthesia
   - Local anesthesia NOT in conjunction with operative or surgical procedures.
   - Regional block
   - Trigeminal division block.
   - Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires hospitalization or general anesthesia. 2 hour maximum time
   - Intravenous conscious sedation/analgesia – 2 hour maximum time
   - Nitrous oxide/analgesia
   - Non-intravenous conscious sedation – to include oral medications
3. Behavior management – for <u>additional</u> time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
   - One unit equals 15 minutes of additional time
   - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
     - Office or Clinic maximum – 2 units
     - Inpatient/Outpatient hospital – 4 units
     - Skilled Nursing/Long Term Care – 2 units
4. Consultation by specialist or non-primary care provider
5. Professional visits
   - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
   - Hospital or ambulatory surgical center call
     - For cases that are treated in a facility.
     - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Policy which requires this admission as in-patient or out-patient. Prior authorization is required.
     - General anesthesia and outpatient facility charges for dental services are covered.
     - Dental services rendered in these settings by a dentist not on staff are considered separately.
   - Office visit for observation – (during regular hours) no other service performed
6. Drugs
   - Therapeutic parenteral drug
     - Single administration
     - Two or more administrations - not to be combined with single administration
   - Other drugs and/or medicaments – by report
7. Application of desensitizing medicament – per visit
8. Occlusal guard – for treatment of bruxism, clenching or grinding
9. Athletic mouthguard covered once per year
10. Occlusal adjustment
    - Limited - (per visit)
    - Complete (regardless of the number of visits), once in a lifetime
11. Odontoplasty
12. Internal bleaching

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.

The Dental Services Deductible does not apply to Diagnostic Services and/or Preventive Services.

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		
Benefit Description	**Network Benefits**	**Out-of-Network Benefits**
Preventive Services (Not subject to payment of the Dental Services Deductible.)	100%	50%
Diagnostic Services (Not subject to payment of the Dental Services Deductible.)	100%	50%
Restorative Services (Subject to payment of the Dental Services Deductible.)	50%	50%
Endodontic Services (Subject to payment of the Dental Services Deductible.)	50%	50%
Periodontal Services (Subject to payment of the Dental Services Deductible.)	50%	50%
Prosthodontic Services (Subject to payment of the Dental Services Deductible.)	50%	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts		
Benefit Description	**Network Benefits**	**Non-Network Benefits**
Oral and Maxillofacial Surgical Services (Subject to payment of the Dental Services Deductible.)	50%	50%
Orthodontic Treatment (Subject to payment of the Dental Services Deductible.)	50%	50%
Adjunctive General Services (Subject to payment of the Dental Services Deductible.)	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. Any Dental Procedure not directly associated with dental disease.
6. 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.
7. Drugs/medications, received with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
8. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
9. Foreign Services are not covered unless required for a Dental Emergency.
10. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
11. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
12. Acupuncture; acupressure and other forms of alternative treatment, except acupuncture when used as a substitute for other forms of anesthesia.
13. 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 Company must be provided with all of the information identified below.

Reimbursement for Dental Services

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.

Claims submitted by the Insured should be submitted within 90 days after the date of services. If it was not reasonably possible to give written proof in the time required, claims will not be reduced or denied for this reason. This time limit does not apply if the Insured is legally incapacitated.

Claims submitted on behalf of the Insured by a Dental Provider should be submitted within 60 days of the last date of services for a course of treatment.

If the Insured has assigned benefits to a Dental Provider, then a claim for payment should be submitted by the Dental Provider within 180 days of the last date of service for a course of treatment. If the Dental Provider does not file the claim within 180 days of the last date of service for a course of treatment, the Company shall reserve the right to deny payment of the claim, in accordance with regulations established by the Commissioner of Banking and Insurance and the Dental Provider shall be prohibited from seeking reimbursement directly from the Insured.

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 other than a member of the Insured Person's immediate family, including spouse, brother, sister, parent or child..

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/Medically 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.

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

This endorsement takes effect and expires concurrently with the Policy to which it is attached and is subject to all 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.

Comprehensive Vision Examination

A comprehensive vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides when performed by an ophthalmologist or optometrist.

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.

Standard frames refer to frames that are not designer frames such as Coach, Burbury, Prada and other designers.

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.

Schedule of Benefits

Vision Care Service	What is the Frequency of Service?	Network Benefit	Out-of-Network Benefit
Comprehensive Vision Examination	Once per year.	100% after a Copayment of $20.	50% of the billed charge.
Eyeglass Lenses One pair of Standard Lenses	Once per year.	100% after a Copayment of $40.	50% of the billed charge.
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
Eyeglass Frames One pair of Standard Frames	Once per year.		
• Eyeglass frames with a retail cost up to $130.		100%.	50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - $160.		100% after a Copayment of $15.	50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - $200.		100% after a Copayment of $30.	50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - $250.		100% after a Copayment of $50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		60%	50% of the billed charge.
Contact Lenses			
• Covered Contact Lens Selection (v2500 – V2599)	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	100% after a Copayment of $40.	50% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

1. Non-prescription items (e.g. Plano lenses).
2. Replacement or repair of lenses and/or frames that have been lost or broken.
3. Optional Lens Extras not listed in Section 1*:* Benefits for Pediatric Vision Care Services.
4. Missed appointment charges.
5. 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 a Vision Services claim is submitted, the Company must be provided 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), all of the following information must be provided 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

Claims submitted by the Insured should be submitted within 90 days after the date of service. If it was not reasonably possible to give written proof in the time required, claims will not be reduced or denied for this reason. This time limit does not apply if the Insured is legally incapacitated.

Claims submitted on behalf of the Insured by a Vision Care Provider should be submitted within 60 days of the last date of services for a course of treatment.

If the Insured has assigned benefits to a Vision Care Provider, then a claim for payment should be submitted by the Vision Care Provider within 180 days of the last date of services for a course of treatment. If the Vision Care Provider does not file the claim within 180 days of the last date of service for a course of treatment, the Company shall reserve the right to deny payment of the claim, in accordance with regulations established by the Commissioner of Banking and Insurance and the Dental Provider shall be prohibited from seeking reimbursement directly from the Insured.

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.

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

UnitedHealthcare Pharmacy (UHCP) 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 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 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 and logging in to their online account or by calling *Customer Service* at 1-855-828-7716.

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

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

Copayment Amount

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

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

The Insured Person is not responsible for paying a Copayment 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, the Insured may receive a Prescription Drug Product up to the stated supply limit. The Company will cover up to a consecutive 90-day supply of a Prescription Drug Product, as written by the Physician, subject to the drug manufacturer’s packaging size, or based on supply limits.

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 that applies will reflect the number of days dispensed. For example: If a prescription is delivered in a 90-day supply, it will be subject to 3 times the 31-day supply Copayment.

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

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

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 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 Specialty Pharmacies

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

If the Insured is directed to a Designated Specialty Pharmacy and chooses not to obtain their Prescription Drug Product from a Designated Specialty Pharmacy, the Insured will be responsible for the entire cost of the Prescription Drug Product.

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 Specialty Pharmacy with whom the Company has an arrangement to provide those Specialty Prescription Drug Products.

If the Insured is directed to a Designated Specialty Pharmacy and chooses not to obtain their Specialty Prescription Drug Product from a Designated Specialty Pharmacy, the Insured will be responsible for the entire cost of the Prescription Drug Product.

Please see the Definitions Section for a full description of Specialty Prescription Drug Product and Designated Specialty 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, subject to 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 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 or Coinsurance that applies will reflect the number of days dispensed.

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

Penalty for Failure to Obtain Prior Authorization:

When the Insured submits a claim on this basis, the Insured may pay more because they did not obtain prior authorization from the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Charge, less the required Copayment and 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. Economic factors are considered when two or more drugs are equivalent in terms of safety, effectiveness and clinical outcome.

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 or call Customer Service at 1-855-828-7716 for the most up-to-date tier status.

Rebates and Other Payments

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

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 Specialty 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 Specialty 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 that is Chemically Equivalent to a Brand-name drug.

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.

PPACA means Patient Protection and Affordable Care Act of 2010.

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

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

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

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

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

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

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

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. Drugs which are prescribed, dispensed or intended for use during an Inpatient stay.
4. 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.
5. 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.
6. A pharmaceutical product for which benefits are provided in the Certificate of Coverage.
7. General vitamins, except the following, which require a Prescription Order or Refill:
   - Prenatal vitamins.
   - Vitamins with fluoride.
   - Single entity vitamins.
8. Certain unit dose packaging or repackagers of Prescription Drug Products.
9. 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.
10. 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.
11. 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.)

12. 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. 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.
13. 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 specifically provided in Benefits for Treatment of Inherited Metabolic Disease and Benefits for Non-Standard Infant Formula.
14. 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.
15. 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.
16. 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.
17. A Prescription Drug Product with either:
    - An approved biosimilar.
    - A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
      For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:
    - It is highly similar to a reference product (a biological Prescription Drug Product).
    - It has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
      Such determinations may be made up to six times during a calendar year. The Company may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
18. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
19. 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.
20. Diagnostic kits and products, including associated services.
21. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.
22. Certain Prescription Drug Products that are *FDA* approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists the Insured Person with the administration of a Prescription Drug Product.

Right to Request an Exclusion Exception

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

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

Urgent Requests

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

External Review

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

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-800-505-4160 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

UnitedHealthcare Insurance Company

Disclosures to Insured Persons Regarding Out-of-Network Treatment

This summary only provides an overview of how an Insured Person's health benefits plan covers Out-of-Network treatment. It is only guidance to help an Insured Person understand their Out-of-Network benefits. This summary does not alter the Insured's coverage in any way.

The Insured Person should refer to their Certificate of Coverage and Schedule of Benefits for more information about Out-of-Network benefits and about coverages and costs for Preferred Provider treatment.

For additional information – including whether a health care professional or facility is a Preferred Provider or an Out-of-Network provider, examples of Out-of-Network costs, and estimates for specific services – please contact the Company at 1-888-889-3473 between 5:00 a.m. and 9:00 p.m. Central Time, or visit our website at: https://www.uhcsr.com/regulatory-state.

Your Policy Covers:	**What this Means:**	**How Am I Protected by NJ law?**
Medically Necessary Treatment on an Emergency or Urgent Basis by Out-of-Network Health Care Professionals/Facilities	Emergency – The Insured is covered for Out-of- Network treatment for a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain; psychiatric disturbances and/or symptoms of Substance Use Disorder such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in: placing the health of the individual or unborn child in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. This includes any further medical examination and such treatment as may be required to stabilize the medical condition. This also includes if there is inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery or such transfer may pose a threat to the health or safety of the woman or unborn child. Urgent – You are covered for Out-of-Network treatment of a non-life-threatening condition that requires care by a health care professional within 24 hours.	Except as discussed below, you should not be billed by an Out-of-Network health care professional or facility, for any amount in excess of any Deductible, Copayment, or Coinsurance amounts (also known as "cost- sharing") applicable to the same services when received at a Preferred Provider facility. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: www.state.nj.us/dobi/consumer.htm.
		We and the Out-of-Network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the emergent/urgent Covered Medical Expenses. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.

		If an agreement cannot be reached, we or the Out-of-Network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the Covered Medical Expenses. The amount awarded by the arbitrator may exceed what we have already paid to the Out-of-Network health care professional/facility; however, any additional amount paid by us pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total Covered Medical Expense for the service(s).

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Inadvertent Out-of- Network services	You are covered for treatment by an Out-of-Network health care professional for Covered Medical Expenses when you use a Preferred Provider health care facility (e.g. hospital, ambulatory surgery center, etc.) and, for any reason, Preferred Provider Covered Medical Expenses are unavailable or services are provided by an Out-of-Network health care professional in that Preferred Provider facility. This includes laboratory testing ordered by a Preferred Provider health care professional and performed by an Out-of-Network bio-analytical laboratory (e.g., imaging, x-rays, blood tests, and anesthesia).	Except as provided below, you should not be billed by an Out-of-Network health care professional or facility, for any amount in excess of any Deductible, Copayment, or Coinsurance amounts (also known as "cost-sharing") applicable to the same Covered Medical Expenses when received from a Preferred Provider. If you receive a bill for any other amount, please contact us at the number above, and/or file a complaint with the Department of Banking and Insurance: https://www.state.nj.us/dobi/consumer.htm We and the Out-of-Network health care professional/facility may negotiate and settle on an amount that is ultimately paid for the inadvertent Out-of-Network Covered Medical Expenses. If that negotiated amount exceeds what was indicated on the initial Explanation of Benefits, your out-of-pocket cost-sharing liability may increase above the amount indicated on the initial Explanation of Benefits. Your total final costs will be provided on the final Explanation of Benefits if settled.

		If an agreement cannot be reached, we or the Out-of-Network health care professional/facility may seek to enter into binding arbitration to determine the amount to be paid for the inadvertent Out-of-Network Covered Medical Expenses. The amount awarded by the arbitrator may exceed what we have already paid to an Out-of-Network health care professional/facility; however, any additional amount paid by us pursuant to the arbitration award will not increase your cost-sharing liability above the amount indicated as your responsibility on the second Explanation of Benefits associated with the last payment made to the health care professional/facility before any arbitration. If arbitration is conducted, you will also receive a final Explanation of Benefits that will show the total Covered Medical Expense for the service(s).

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Treatment from Out-of-Network health care professionals/ facilities if Preferred Provider health care professionals/facilities are unavailable.	Plans are required to have adequate networks to provide you with access to professionals/facilities within certain time/distance requirements so you can obtain Medically Necessary treatment of all Sicknesses or Injuries covered by your plan.	You can request treatment from an Out-of-Network health care professional/facility when a Preferred Provider health care professional/facility is unavailable through an appeal, often called a request for an "in- plan exception." Please see the Department of Banking and Insurance's guide at: https://nj.gov/dobi/appeal/.

Your Policy Covers:	What this Means:	How Am I Protected by NJ law?
Voluntary Out-of-Network Covered Health Care Services	You are covered for treatment by an Out-of-Network health care professional/facility when you knowingly, voluntarily and specifically select an Out-of-Network health care professional/facility, even if you have the opportunity to be serviced by a Preferred Provider health care professional/facility. We will cover voluntary Out-of-Network Covered Medical Expenses as described in your Certificate of Coverage and Schedule of Benefits. Please see the Schedule of Benefits for cost shares applicable to Out-of-Network Covered Medical Expenses.	Carriers must provide ready access to information about how to determine when a health care professional/facility is a Preferred Provider. Please contact us if you have any questions about the status of a particular professional/facility. Additionally, health care professionals/facilities must disclose to you, in writing or on a website, the plans in which they participate as a Preferred Provider. Note, indications that a professional/facility "accepts" a certain health plan does not necessarily indicate Preferred Provider status. So, when seeking treatment, you can check with both us and your prospective health care professional/facility.

	Please be advised that the Covered Medical Expense (discussed above) is not the same as the amount billed by your Out-of-Network Health Care Professional/Facility, and is usually less. We calculate the Covered Medical Expense as indicated in the Schedule of Benefits.	Carriers must provide a method to enable you to be able to calculate an estimate of Out-of-Network costs when voluntarily seeking to use an Out-of-Network health care professional/facility. You can contact us via the methods above to obtain more information regarding the Usual and Customary Charges for specific Covered Medical Expense if you can provide a Current Procedural Terminology (CPT) code. If you do not have a CPT code, you can estimate your costs by visiting https://www.uhcsr.com/regulatory-state and selecting *NJ-Out-of-Network Treatments*.
	You will be responsible for payment of: a) Your cost-sharing portion of the Covered Medical Expense as disclosed above; plus, b) the difference between the Usual and Customary Charge and the amount the Out-of-Network health care professional/facility bills for the services (commonly referred to as the "balance bill").	You can also visit our website above for examples of the average costs (allowed amount, billed amount, consumer responsibility without cost-sharing under plan) for ten most frequently billed Out-of-Network services.

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 http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

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
ᏕᏋᏂᏣᏍᏗ ᎤᎾᏓᏍᏕᏆᏗ ᎤᎾᏓᏡᎬᎢ ᏂᏯ ᎡᏩᏠᏅᎢᏍᏓᏗᏄᎢ ᏂᏓᎬᏩᏠᎾ ᎠᏎᏇᎢ. ᎰᏩᏇ ᎠᏂ ᏫᏏᏔᏠᏕ 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 ho̱ 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
ကျိာ်တၢ်မၤစၢၤအဂီၢ်နမၤန့ၢ်အီၤသ့ဒဲလၢတလိာ်ဟ့ၣ်အပ့ၤဘၣ်(ခီလီ)နၣ်လီၤ.
ဖဲသးစူၤဆဲးကျိးဘၣ်1-866-260-2723တက့ၢ်.

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 ejjeļọk wōņāān. Jouj im kaļọk 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
ܚܕ̈ܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ، ܡܨܛܒܝܢܐ ܐܢܐ ܟܠܗ̇ܘܢ ܡܓܢܐܝܬ. ܩܪܝܘܢ
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
Isẹ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.