

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR

Filing at a Glance

Company: UnitedHealthcare Insurance Company
Product Name: Blanket Student Association Injury and Sickness Policy
State: Arkansas
TOI: H04 Health - Blanket Accident/Sickness
Sub-TOI: H04.001 Student
Filing Type: Form
Date Submitted: 10/18/2012
SERFF Tr Num: UHLC-128731917
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: COL-12A-AR

Implementation: On Approval
Date Requested:
Author(s): Mark Wenshau
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 11/13/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR

General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: COL-12A-AR Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: State-specific forms have been filed in our state of domicile Connecticut.
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Large
Group Market Type: Association Overall Rate Impact:
Filing Status Changed: 11/13/2012
State Status Changed: 11/13/2012 Deemer Date:
Created By: Mark Wenshau Submitted By: Mark Wenshau
Corresponding Filing Tracking Number:
PPACA: Non-Grandfathered Immed Mkt Reforms
PPACA Notes: null
Include Exchange Intentions: No

Filing Description:

Enclosed for your consideration and approval is our original submission of the above referenced blanket student association injury and sickness policy. Form COL-12A-AR will be marketed to student associations in your state to insure colleges and university students who are members of the student association. This form is being filed as a result of PPACA and the final rule for student health insurance coverage, which makes a distinction between student health coverage provided to a policy issued to an institution of higher education and that issued to a student association. This plan is being filed for use with the 2012-2013 policy year.

The policy received a Flesch readability score of 45.1.

This form filing is being filed concurrently in our domiciliary state of Connecticut.

Also enclosed is the required certifications, filing forms and listing of forms for approval.

Company and Contact

Filing Contact Information

Mark Wenshau, Compliance Analyst mwenshau@uhcsr.com
UnitedHealthcare 866-808-8305 [Phone] 6859 [Ext]
StudentResources 469-229-5535 [FAX]
2301 W. Plano Parkway
Suite 300
Plano, TX 75075

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR

Filing Company Information

UnitedHealthcare Insurance Company	CoCode: 79413	State of Domicile: Connecticut
185 Asylum Street	Group Code: 707	Company Type: Life and Health
Hartford, CT 06103	Group Name:	State ID Number:
(860) 702-5000 ext. [Phone]	FEIN Number: 36-2739571	

Filing Fees

Fee Required? Yes
 Fee Amount: \$1,000.00
 Retaliatory? No
 Fee Explanation: \$50/form X 20 Forms = \$1,000.00
 Per Company: No

Company	Amount	Date Processed	Transaction #
UnitedHealthcare Insurance Company	\$1,000.00	10/18/2012	64024970

State: Arkansas
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
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Filing Company: UnitedHealthcare Insurance Company

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/13/2012	11/13/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	11/06/2012	11/06/2012
Pending Industry Response	Rosalind Minor	11/02/2012	11/02/2012
Pending Industry Response	Rosalind Minor	10/24/2012	10/24/2012

Response Letters

Responded By	Created On	Date Submitted
Mark Wenshau	11/06/2012	11/06/2012
Mark Wenshau	11/05/2012	11/05/2012
Mark Wenshau	10/31/2012	10/31/2012

State: Arkansas
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Filing Company: UnitedHealthcare Insurance Company
Project Name/Number: /COL-12A-AR

Disposition

Disposition Date: 11/13/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Form Filing List	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Objection Response Ltrr 10-31-12	Approved-Closed	Yes
Supporting Document	Objection Response Ltrr 11-05-12	Approved-Closed	Yes
Supporting Document	Objection Response Ltrr 11-06-12	Approved-Closed	Yes
Form (revised)	Blanket Student Association Injury and Sickness Policy	Approved-Closed	Yes
Form	Blanket Student Association Injury and Sickness Policy	Replaced	Yes
Form	Schedule of Benefits - Usual and Customary	Approved-Closed	Yes
Form	Schedule of Benefits - PPO	Approved-Closed	Yes
Form	Policyholder Application	Approved-Closed	Yes
Form	Application Attachment	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes

SERFF Tracking #:

UHLC-128731917

State Tracking #:**Company Tracking #:**

COL-12A-AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name:

Blanket Student Association Injury and Sickness Policy

Project Name/Number:

/COL-12A-AR

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Resolution of Grievances	Approved-Closed	Yes
Form	Mandated Offer Endorsement	Approved-Closed	Yes
Form	Mandated Offer Endorsement	Approved-Closed	Yes
Form	Mandated Offer Endorsement	Approved-Closed	Yes
Form	Mandated Offer Endorsement	Approved-Closed	Yes

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/06/2012
Submitted Date	11/06/2012
Respond By Date	

Dear Mark Wenshau,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Blanket Student Association Injury and Sickness Policy, COL-12A-AR (Form)

Comments:

As discussed in our telephone conversation on 11/5/12, it is requested that you add, under Entire Contract Changes, the wording: "In the absence of Fraud".

We appreciate your continued cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/02/2012
Submitted Date	11/02/2012
Respond By Date	

Dear Mark Wenshau,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Blanket Student Association Injury and Sickness Policy, COL-12A-AR (Form)

Comments: Under Part II, Entire Contract Changes, please add a statement that reads: that " all statements made by the policyholder shall, in the absence of fraud, be deemed representations and not warranties....". Please review ACA 23-86-102(1).

Thank you for your cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas **Filing Company:** UnitedHealthcare Insurance Company
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/24/2012
Submitted Date	10/24/2012
Respond By Date	

Dear Mark Wenshau,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Blanket Student Association Injury and Sickness Policy, COL-12A-AR (Form)

Comments:

Your submission has been thoroughly reviewed by our Department.

Before approval is given to this filing, it is requested that you provide us with a few examples of the student associations. It is also requested that you certify that benefits payable In Network and Out-of-Network comply with our Bulletin 9-85 which states in part that benefits payable will not be greater than 25%.

We appreciate your cooperation in this matter.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Filing Company: UnitedHealthcare Insurance Company
Project Name/Number: /COL-12A-AR

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/06/2012
Submitted Date	11/06/2012

Dear Rosalind Minor,

Introduction:

Thank you for taking the time to call me yesterday. Please find our revised policy and Objection response letter dated today attached below.

Response 1

Comments:

I have attached my response letter and a revised policy for your review.

Related Objection 1

Applies To:

- Blanket Student Association Injury and Sickness Policy, COL-12A-AR (Form)

Comments:

As discussed in our telephone conversation on 11/5/12, it is requested that you add, under Entire Contract Changes, the wording: "In the absence of Fraud".

We appreciate your continued cooperation.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Objection Response Ltrr 11-06-12
Comments:	
Attachment(s):	
	Objection Response 11-06-12.pdf

State: Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name: Blanket Student Association Injury and Sickness Policy

Project Name/Number: /COL-12A-AR

Form Schedule Item Changes:**Form Schedule Item Changes**

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Blanket Student Association Injury and Sickness Policy	COL-12A-AR	POL	Initial			COL-12A-AR.pdf	Date Submitted: 11/06/2012 By: Mark Wenshau
<i>Previous Version</i>								
1	<i>Blanket Student Association Injury and Sickness Policy</i>	<i>COL-12A-AR</i>	<i>POL</i>	<i>Initial</i>			<i>COL-12A-AR.pdf</i>	<i>Date Submitted: 10/18/2012 By: Mark Wenshau</i>

No Rate/Rule Schedule items changed.

Conclusion:

Please let me know if you need anything further from me.

Thanks!

Sincerely,

Mark Wenshau

State: Arkansas
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR
Filing Company: UnitedHealthcare Insurance Company

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/05/2012
Submitted Date	11/05/2012

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

My objection response letter with today's date is attached for your review.

Thanks

Related Objection 1

Applies To:

- Blanket Student Association Injury and Sickness Policy, COL-12A-AR (Form)

Comments: Under Part II, Entire Contract Changes, please add a statement that reads: that " all statements made by the policyholder shall, in the absence of fraud, be deemed representations and not warranties....". Please review ACA 23-86-102(1).

Thank you for your cooperation.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Objection Response Ltrr 11-05-12
Comments:	
Attachment(s):	
Objection Response 11-05-12.pdf	

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

SERFF Tracking #:

UHLC-128731917

State Tracking #:

Company Tracking #:

COL-12A-AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name:

Blanket Student Association Injury and Sickness Policy

Project Name/Number:

/COL-12A-AR

Please let me know if you need anything further.

Thank you.

Sincerely,

Mark Wenshau

State: Arkansas
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Filing Company: UnitedHealthcare Insurance Company
Project Name/Number: /COL-12A-AR

Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/31/2012
 Submitted Date 10/31/2012

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

Ms. Minor,

Attached, please find my objection response letter dated 10/31/12.

Related Objection 1

Applies To:

- Blanket Student Association Injury and Sickness Policy, COL-12A-AR (Form)

Comments:

Your submission has been thoroughly reviewed by our Department.

Before approval is given to this filing, it is requested that you provide us with a few examples of the student associations. It is also requested that you certify that benefits payable In Network and Out-of-Network comply with our Bulletin 9-85 which states in part that benefits payable will not be greater than 25%.

We appreciate your cooperation in this matter.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Objection Response Ltr 10-31-12
Comments:	
Attachment(s):	
Objection Response 10-31-12.pdf	

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

SERFF Tracking #:

UHLC-128731917

State Tracking #:

Company Tracking #:

COL-12A-AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name:

Blanket Student Association Injury and Sickness Policy

Project Name/Number:

/COL-12A-AR

Please let me know if I can be of further assistance to you.

Thanks,

Sincerely,

Mark Wenshau

State: Arkansas
TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student
Product Name: Blanket Student Association Injury and Sickness Policy
Project Name/Number: /COL-12A-AR

Filing Company: UnitedHealthcare Insurance Company

Form Schedule

Lead Form Number: COL-12A-AR								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/13/2012	Blanket Student Association Injury and Sickness Policy	COL-12A-AR	POL	Initial			COL-12A-AR.pdf
2	Approved-Closed 11/13/2012	Schedule of Benefits - Usual and Customary	COL-12A-AR SOB	SCH	Initial			COL-12A-AR SOB.pdf
3	Approved-Closed 11/13/2012	Schedule of Benefits - PPO	COL-12A-AR SOB PPO	SCH	Initial			COL-12A-AR SOB PPO.pdf
4	Approved-Closed 11/13/2012	Policyholder Application	COL-12A-AR AP1	AEF	Initial			COL-12A-AR AP1.pdf
5	Approved-Closed 11/13/2012	Application Attachment	COL-12A-AR AP2	AEF	Initial			COL-12A-AR AP2.pdf
6	Approved-Closed 11/13/2012	Endorsement	COL-12A-AR END (5A)	POLA	Initial			COL-12A-AR END (5A) Excess Provision.pdf
7	Approved-Closed 11/13/2012	Endorsement	COL-12A-AR END (5B)	POLA	Initial			COL-12A-AR END (5B) Excess Provision.pdf
8	Approved-Closed 11/13/2012	Endorsement	COL-12A-AR END (5C)	POLA	Initial			COL-12A-AR END (5C) Coordination of Benefits.pdf

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name:

Blanket Student Association Injury and Sickness Policy

Project Name/Number:

/COL-12A-AR

Lead Form Number: COL-12A-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
9	Approved-Closed 11/13/2012	Endorsement	COL-12A END (6B)	POLA	Initial			COL-12A END (6B) Accidental Death and Dismemberment.pdf
10	Approved-Closed 11/13/2012	Endorsement	COL-12A END (6E)	POLA	Initial			COL-12A END (6E) Accidental Death and Dismemberment.pdf
11	Approved-Closed 11/13/2012	Endorsement	COL-12A END (7)	POLA	Initial			COL-12A END (7) Pre-Admission Notification.pdf
12	Approved-Closed 11/13/2012	Endorsement	COL-12A END (12)	POLA	Initial			COL-12A END (12) Dental Benefits.pdf
13	Approved-Closed 11/13/2012	Endorsement	COL-12A END (15)	POLA	Initial			COL-12A END (15) Live Organ or Bone Marrow Donor.pdf
14	Approved-Closed 11/13/2012	Endorsement	COL-12A END (16)	POLA	Initial			COL-12A END (16) Continuation Privilege.pdf
15	Approved-Closed 11/13/2012	Endorsement	COL-12A END (RX)	POLA	Initial			COL-12A END (RX) Prescription Drug Benefits.pdf

State: Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name: Blanket Student Association Injury and Sickness Policy

Project Name/Number: /COL-12A-AR

Lead Form Number: COL-12A-AR

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
16	Approved-Closed 11/13/2012	Resolution of Grievances	GR-12-AR	POLA	Initial			GR-12-AR Grievance Notice.pdf
17	Approved-Closed 11/13/2012	Mandated Offer Endorsement	COL-12AMOE-AR END (3)	POLA	Initial			COL-12AMOE-AR END (3) Mammo.pdf
18	Approved-Closed 11/13/2012	Mandated Offer Endorsement	COL-12AMOE-AR END (5)	POLA	Initial			COL-12AMOE-AR END (5) TMJ.pdf
19	Approved-Closed 11/13/2012	Mandated Offer Endorsement	COL-12AMOE-AR END (6)	POLA	Initial			COL-12AMOE-AR END (6) Hospice.pdf
20	Approved-Closed 11/13/2012	Mandated Offer Endorsement	COL-12AMOE-AR END (8)	POLA	Initial			COL-12AMOE-AR END (8) Hearing Aids.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

UHLC-128731917

State Tracking #:

Company Tracking #:

COL-12A-AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name:

Blanket Student Association Injury and Sickness Policy

Project Name/Number:

/COL-12A-AR

POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office Address: P.O. Box 809025, Dallas, TX 75380-9025
BLANKET STUDENT ASSOCIATION ACCIDENT AND SICKNESS POLICY

POLICYHOLDER	[ANY STUDENT ASSOCIATION]	POLICY NUMBER	[12-0000]
ADDRESS	[111 ANY ST.]	Effective Date	[2012-2013] ACADEMIC YEAR
	[ANY CITY, STATE]	Termination Date	[2012-2013] ACACEMIC YEAR

PREMIUM FOR EACH INSURED PERSON

SEE APPLICATION ATTACHED

LIST OF ENDORSEMENTS ATTACHED TO AND FORMING A PART OF THIS POLICY

UNITEDHEALTHCARE INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this policy to pay the benefits provided by this policy for loss resulting from a cause covered by this policy. This policy is issued in consideration of the application and payment of the premiums. Premiums as specified above are payable for each Insured Person.

Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed



President

Countersigned by _____ Licensed Resident Agent

PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1) two years after the termination of this policy and 2) the date of final adjustment and settlement of all claims under this policy.

TABLE OF CONTENTS

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PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. [[The Named Insured must actively attend classes for at least the first [31 [1-45]] days after the date for which coverage is purchased.] [[Home study,] [correspondence,] [and] [online] courses do not fulfill the eligibility requirements[that the Named Insured actively attend classes].] The Company maintains its right to investigate [eligibility or] student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.]

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

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

[Dependent eligibility expires concurrently with that of the Named Insured.]]

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

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

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

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

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

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

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

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

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

PART II
GENERAL PROVISIONS

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. All statements made by the Policyholder shall, in the absence of fraud, be deemed representations and not warranties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the insured enters the armed forces. [Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment.] [The Named Insured may purchase optional coverages for himself or for himself and all Dependent family members[, unless the optional coverage is available only to the Named Insured.]]

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

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

CLAIM FORMS: [Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.] [Claim forms are not required.]

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

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

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

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

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

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

In the event that the Insured recovers from the third party, reasonable cost of collection and attorney's fees thereof shall be assessed against the Company and the Insured in the proportion each benefits from the recovery. In the event more than one casualty insurer, health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement or hospital or medical services corporation having contractual subrogation rights are entitled to the subrogation benefits, reasonable cost of collection and attorney's fees thereof shall be assessed against the insurers and the Insured in the proportion each benefits from the recovery.

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

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

PART III DEFINITIONS

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

[**DEPENDENT** means the spouse (husband or wife) [or Domestic Partner] of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of [26 – 30] years.

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

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

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

Dependent shall also include any minor under the charge, care and control of the Named Insured that the Insured has filed a petition to adopt. Coverage shall begin:

- 1) On the date of the filing of the petition for adoption, provided the Named Insured applies within sixty (60) days after the filing of the petition for adoption; or
- 2) From the moment of birth, provided the petition for adoption and application for coverage is filed within (60) days after the birth of the minor.

Coverage shall terminate upon the dismissal or denial of a petition for adoption.]

[DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; [and] 3) is responsible with the Named Insured for each other's welfare; and 4) is the same sex as the Named Insured]. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.]

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

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

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

INJURY means bodily injury which is all of the following:

- 1) directly and independently caused by specific accidental contact with another body or object.
- 2) unrelated to any pathological, functional, or structural disorder.
- 3) a source of loss.
- 4) treated by a Physician within [30 - 365] days after the date of accident.
- 5) sustained while the Insured Person is covered under this policy.

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

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

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

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

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

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

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

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

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

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

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

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

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

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

[NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 90 days after birth. Coverage for such a child will be for Injury or Sickness, including congenital defects, premature birth, and tests for hypothyroidism, phenylketonuria and galactosemia, and, in the case of non-Caucasian Newborn Infants, tests for sickle-cell anemia, as well as any testing of Newborn Infants hereafter mandated by law and shall also include coverage to pay for routine nursery care and pediatric charges for a well Newborn Infant for up to five (5) full days in a hospital nursery, or until the mother is discharged from the hospital following the birth of the child, whichever is less.

[The Insured will have the right to continue such coverage for the child beyond the first 90 days. To continue the coverage the Insured must, within the 90 days after the child's birth: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 90 days after the child's birth.]]

[OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

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

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

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

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

[PRE-EXISTING CONDITION means[: 1) the existence of symptoms [which would cause an ordinarily prudent person to seek diagnosis, care or treatment] within the [3 - 12] months immediately prior to the Insured's Effective Date under the policy; or, 2)] any condition which [originates,] is diagnosed, treated or recommended for treatment within the [3 - 12] months immediately prior to the Insured's Effective Date under the policy.]

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

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

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

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

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

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

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

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

**[PART IV
[COVERED LOSS - TIME LIMITS**

Covered Medical Expenses will be paid under the Schedule of Benefits for loss[:]

- [1)] Due to Injury to an Insured Person provided that treatment by a Physician: a) begins within [30 – 365] days after the date of Injury; and, b) is received within [12 – 24] months after date of Injury[; or,
- 2) Due to Sickness of an Insured Person provided Covered Medical Expenses are incurred within [12 – 24] months after the date of first treatment for such Sickness].]

[EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury [or Sickness] for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury [or Sickness] will continue to be paid as long as the condition continues but not to exceed [[30 – 365] days] [[12 – 24] months] after the Termination Date.

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

[EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured incurs medical expenses within [30 - 365] days of 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:

- 1) When not Hospital Confined on the Termination Date, not to exceed [30 – 365] days after the Termination Date; or
- 2) When Hospital Confined on the Termination Date, not to exceed [[30 – 365] days] [[12 – 24] months] after the Termination Date.

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

If the Insured is also an Insured under the succeeding policy issued to the Policyholder; this "Extension of Benefits" provision will not apply.]]

INSERT
SCHEDULE OF BENEFITS
HERE

[PART [VI]
PREFERRED PROVIDER INFORMATION

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

[List Preferred Providers in School Area here]]

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling [the Company at [1-800-767-0700]] and/or by asking the provider when making an appointment for services.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

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

[**“Network Area”** means the [10 – 50] mile radius around the local school campus the Named Insured is attending.]

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at [[50 – 100]% [the Coinsurance percentages specified in the Schedule of Benefits], up to any limits specified in the Schedule of Benefits. [Preferred Hospitals include [UnitedHealthcare Options PPO] United Behavioral Health (UBH) facilities.] Call [(800) 767-0700] for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

[Professional & Other Expenses

Benefits for Covered Medical Expenses provided by [name of network or Physician groups] will be paid at [[50 – 100]% of Preferred Allowance] [the Coinsurance percentages specified in the Schedule of Benefits]-or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.]

[SPECIAL PROVIDER ARRANGEMENTS

[Affiliated Physicians, Inc. and Doctors Walk-In Clinics] [have] agreed to accept special reduced reimbursement rates for treatment rendered to Insureds. Eligible [Physician] services provided by [Affiliated Physicians, Inc. and Doctors Walk-In Clinics] will be paid at [[50 – 100]% of these negotiated 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.]]

PART [VII]
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any Coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

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

1. **Room and Board Expense:** 1) daily semi-private room rate when confined as an Inpatient; and 2) general nursing care provided and charged by the Hospital.
2. **[Intensive Care:** If provided in the Schedule of Benefits.]
3. **[Hospital Miscellaneous Expenses:** 1) when confined as an Inpatient; or 2) as a precondition for being confined as an Inpatient. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; [therapeutic services;] and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.]
4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.
5. **[Physiotherapy (Inpatient):** See Schedule of Benefits.]
6. **Surgery:** Physician's fees for Inpatient surgery. [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]
7. **[Assistant Surgeon Fees:** in connection with Inpatient surgery, if provided in the Schedule of Benefits.]
8. **Anesthetist Services:** professional services administered in connection with Inpatient surgery.
9. **Registered Nurse's Services:** [1] private duty nursing care only; [2] while an Inpatient; [3] ordered by a licensed Physician; and [4] a Medical Necessity. General nursing care provided by the Hospital[, Skilled Nursing Facility] [or] [Inpatient Rehabilitation Facility] is not covered under this benefit.
10. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. [Benefits are limited to one visit per day.] [Benefits do not apply when related to surgery.] [Covered Medical Expenses will be paid under the Inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.]
11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. [This benefit is payable within [3 - 14] working days prior to admission.]
12. **Surgery (Outpatient):** Physician's fees for outpatient surgery. [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, The maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]

13. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery[; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic]. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
14. **[Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.]
15. **[Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.]
16. **Physician's Visits (Outpatient):** [benefits are limited to one visit per day.] [Benefits do not apply when related to [surgery][or] [Physiotherapy].] [Benefits include [surgery,] [X-rays,] [laboratory procedures] [and] [tests and procedures] when performed in the Physician's Office.] [Covered Medical Expenses will be paid under the outpatient benefit or under the Inpatient benefit for Physician's Visits, but not both on the same day.] Physician's Visits for preventive care are provided as specified under Preventive Care Services.
17. **[Physiotherapy (Outpatient):** [benefits are limited to one visit per day]. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) See also Benefits for the Treatment of Speech and Hearing Disorders. [Review of Medical Necessity will be performed after [12 - 24] visits per [Injury] [or] [Sickness].]
18. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for [the attending Physician's charges,] [X-rays,] [laboratory procedures,] [tests and procedures,] [injections,] the facility charge for use of the emergency room and supplies. [Treatment must be rendered within [72][48-120] hours from time of Injury or first onset of Sickness.]
19. **Diagnostic X-ray Services (Outpatient):** [Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.] X-ray services for preventive care are provided as specified under Preventive Care Services.
20. **[Radiation Therapy (Outpatient):** See Schedule of Benefits.]
21. **Laboratory Procedures (Outpatient):** [Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.] Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
22. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit: inhalation therapy; infusion therapy; pulmonary therapy; and respiratory therapy. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.
23. **[Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.]
24. **[Chemotherapy (Outpatient):** See Schedule of Benefits.]
25. **[Prescription Drugs (Outpatient):** See Schedule of Benefits.]
26. **[Ambulance Services:** See Schedule of Benefits.]
27. **[Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. See also Benefits for Orthotic and Prosthetic Devices and Services. [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.]
28. **[Consultant Physician Fees:** [when requested and approved by the attending Physician.]]

29. **[Dental Treatment:** [1)] performed by a Physician[; and, 2) made necessary by Injury to Sound, Natural Teeth]. [Breaking a tooth while eating is not covered.] [Routine dental care and treatment to the gums are not covered.]]
30. **Mental Illness Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; and 2) on an outpatient basis including intensive outpatient treatment. [Benefits are limited to one visit per day.]
31. **Substance Use Disorder Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; 2) on an outpatient basis including intensive outpatient treatment. [Benefits are limited to one visit per day.]
32. **Maternity:** Same as any other Sickness. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.
33. **Complications of Pregnancy:** Same as any other Sickness.
34. **Preventive Care Services:** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
35. **Reconstructive Breast Surgery Following Mastectomy:** same as any other Sickness and in connection with a covered mastectomy. See Benefits for Mastectomy and Reconstructive Breast Surgery.
36. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.
37. **[High Cost Procedures:** any outpatient procedure costing over \$[200 – 1,000]. High Cost Procedures includes: 1) C.A.T. Scan; 2) Magnetic Resonance Imaging; and 3) Laser treatment, which must be provided on an outpatient basis.]
38. **[Home Health Care:** services received from a licensed home health agency that are: 1) ordered by a Physician; 2) provided or supervised by a Registered Nurse in the Insured Person’s home; and 3) pursuant to a home health plan. Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.]
39. **[Hospice Care:** when recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. Hospice care includes physical, psychological, social, and spiritual care for the terminally ill Insured and short-term grief counseling for immediate family members while the Insured is receiving hospice care. All hospice care must be received from a licensed hospice agency.]
40. **[Inpatient Rehabilitation Facility:** services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.]
41. **[Skilled Nursing Facility:** services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered: 1) in lieu of Hospital Confinement as a full-time inpatient; or 2) within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.]
42. **[Urgent Care Center:** benefits are limited to the[1)] facility or clinic fee billed by the Urgent Care Center[; and 2) the [attending Physician’s charges,] [X-rays,] [laboratory procedures,] [tests and procedures,] [and] [injections]]. [All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]]

43. **[Hospital Outpatient Facility or Clinic:** benefits are limited to[: 1] the facility or clinic fee billed by the Hospital[; and 2) the attending Physician's charges,] [X-rays,] [laboratory procedures,] [tests and procedures,] [and] [injections]]. [All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]]
44. **[Approved Clinical Trials:** Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include: 1) the experimental or investigational item, device or service, itself; 2) 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; or 3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

45. **[[Optional] Repatriation [(International) Students Only]:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. [This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under this policy.] [This optional benefit is subject to payment of the additional premium as specified on the application.]]
46. **[[Optional] Medical Evacuation [(International) Students Only]:** 1) when Hospital Confined for at least [three - five] consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. [This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under this policy.] [This optional benefit is subject to payment of the additional premium as specified on the application.]]
47. **[Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.]

**PART [VIII]
MANDATED BENEFITS**

BENEFITS FOR DRUGS FOR TREATMENT OF CANCER

If benefits are provided under the policy for Prescription Drugs, benefits will be paid the same as any other Sickness for any drug approved by the United States Food and Drug Administration (F.D.A.) for use in the treatment of cancer subject to the following criteria. Benefits may not be limited or excluded on the basis that the drug has not been approved by the United States FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided that the drug has been recognized as safe and effective treatment for that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more such compendia:

1. The American Hospital Formulary Service Drug Information;
2. The National Comprehensive Cancer Network Drugs and Biologics Compendium;
3. The Elsevier Gold Standard's Clinical Pharmacology;

or the drug has been recognized as safe and effective treatment for that specific type of cancer in two articles from major peer-review professional medical journals that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from a major peer-reviewed professional medical journal, or other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the Commissioner.

Coverage of such drugs includes all services that are a Medical Necessity associated with the administration of the drug, provided such services are covered by the policy.

This provision shall not be construed to do any of the following:

1. Require coverage for any drug if the United States FDA has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed;
2. Require coverage for any experimental or investigational drug as defined by the policy;
3. Require coverage for any experimental or investigational dosage or application of a drug as defined by the policy;
4. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States FDA; or
5. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the treatment of diabetes mellitus, including but not limited to Type I, Type II, and gestational diabetes, for medically appropriate and necessary equipment and supplies, including podiatric appliances when prescribed by a Physician. Benefits will include training programs for diabetes self-management training and educational services used to treat diabetes, when determined by the Insured's treating Physician to be medically necessary and when provided by an appropriately licensed health care professional,. Diabetes self-management training, educational services and nutrition counseling must be provided under the direct supervision of a Physician.

"Diabetes self-management training" means instruction in an inpatient or outpatient setting. This includes medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

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

BENEFITS FOR MASTECTOMY AND RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness for mastectomy and reconstructive breast surgery following a mastectomy on one or both breasts to produce a symmetrical appearance including coverage of prostheses and physical complications of mastectomy, including lymphedemas.

Mastectomy benefits shall provide for medical and surgical benefits for any hospital stay in connection with a mastectomy for not less than forty-eight hours unless the decision to discharge the patient before the expiration of the minimum length of stay is made by an attending 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 IN VITRO FERTILIZATION

Benefits will be paid the same as any other Sickness for in vitro fertilization procedures performed at medical facilities licensed or certified by the Arkansas Department of Health as an in vitro fertilization clinic. If no such facility is licensed or certified in this State or no such licensing program is operational, then coverage shall be extended for any procedures performed at a facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Benefits will be paid for in vitro fertilization services to the same extent as the benefits provided for other pregnancy-related procedures not to exceed a \$15,000 Maximum Lifetime Benefit provided that:

1. The patient is the Named Insured or the spouse of the Named Insured and a covered Dependent under this policy;
2. The patient's oocytes are fertilized with the sperm of the patient's spouse;
3. The patient and the patient's spouse have a history of unexplained infertility of at least (2) two years duration; or
4. The infertility is associated with one or more of the following medical conditions:
 - a. Endometriosis;
 - b. Exposure in utero to Diethylstilbestrol, commonly known as DES; or
 - c. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy);
5. The patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy.

Cryopreservation, the procedure whereby embryos are frozen for later implantation, shall be included as an in vitro fertilization procedure.

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

[BENEFITS FOR CHILDREN'S PREVENTIVE HEALTH CARE SERVICES

Benefits will be provided for Periodic Preventive Care Visits for covered Dependent children from the moment of birth through the age of eighteen (18) as specified below.

Benefits for Children's Preventive Health Care Services will include twenty (20) visits at approximately the following age intervals: birth, two (2) weeks, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years, six (6) years, eight (8) years, ten (10) years, twelve (12) years, fourteen (14) years, sixteen (16) years, and eighteen (18) years. Benefits will be provided only to the extent that these services are provided by or under the supervision of a single Physician during the course of one (1) visit.

Benefits will be reimbursed at levels established by the Arkansas Insurance Commissioner.

"Children's preventive health care services" means Physician-delivered or Physician-supervised services for covered Dependents from birth through age eighteen (18) for Periodic Preventive Care Visits including medical history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

"Periodic preventive care visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Benefits for the recommended immunization services will be exempt from any copayment, coinsurance, Deductible or dollar limitation provisions in the policy. All other Children's Preventive Health Care Services will be subject to all Copayment, Coinsurance, and Deductible or dollar limitation provisions in the policy.]

BENEFITS FOR PHENYLKETONURIA TREATMENT

Benefits will be paid the same as any other Sickness for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a Physician for the therapeutic treatment of phenylketonuria or other inherited metabolic disease.

Benefits will be payable after the cost of the Medical Food or low protein modified food products for an individual or a family with a Dependent child or children exceeds the two thousand four hundred dollars (\$2,400) per year per child income tax credit allowed under Arkansas Code, s 23-79-702.

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry; (4) "Low protein modified food product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

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

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

BENEFITS FOR TREATMENT OF SPEECH AND HEARING DISORDERS

Benefits will be paid the same as any other Sickness for the necessary care and treatment of Loss or Impairment of Speech or hearing subject to all terms and conditions of the policy.

The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology, and which fall within the scope of his or her area of certification.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a Hospital or ambulatory surgical facility, if the Physician treating the patient certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Insured is:

1. A child under seven years of age who is determined by two dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment in a Hospital or ambulatory surgical center for a significantly complex dental condition;
2. A person with a diagnosed serious mental or physical condition; or
3. A person with a significant behavioral problem as determined by the covered person's physician as licensed under the Arkansas Medical Practices Act.

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening performed by a qualified medical professional.

Benefits include at least one screening per policy year for any male Insured Person forty (40) years of age or older in accordance with the National Comprehensive Cancer Network guidelines.

If a Physician recommends that an Insured Person undergo a Prostate Specific Antigen (PSA) blood test, benefits may not be denied on the ground that the Insured Person has already had a digital rectal examination and the examination was negative.

This benefit is not subject to the policy Deductible and will not reduce or limit any other diagnostic benefits otherwise payable under this policy, This benefit shall be subject to all other Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR ORTHOTIC AND PROSTHETIC DEVICES AND SERVICES

Benefits will be paid for Orthotic and Prosthetic Devices and Services when such devices and services are: (1) prescribed by a licensed doctor of medicine, doctor of osteopathy, doctor of podiatric medicine; and (2) provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

Benefits include replacement of an Orthotic or Prosthetic device and related services, but not more frequently than one (1) time every three (3) years, unless medically necessary or necessitated by anatomical change or normal use.

"Orthotic device" means an external device that is: a.) Intended to restore physiological function or cosmesis to a patient; and b) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

"Orthotic device" does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: a) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and b) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body;

"Orthotic service" means the evaluation and treatment of a condition that requires the use of an orthotic device;

"Prosthetic device" means an external device that is: a) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and b) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

"Prosthetic device" does not include an artificial eye, an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body;

"Prosthetic service" means the evaluation and treatment of a condition that requires the use of a prosthetic device;

The benefit amount shall be no less than [eighty] percent [(80%)] of the Medicare allowable amount.

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

[BENEFITS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Benefits will be paid the same as any other Sickness for the Treatment of Autism Spectrum Disorder.

Autism Spectrum Disorder means: Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders", including:

- (A) Autistic disorder;
- (B) Asperger's disorder; and
- (C) Pervasive developmental disorder not otherwise specified;

Treatment includes:

- (A) The following care prescribed, provided, or ordered for a specific individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary and evidence-based including without limitation:
 - (i) Applied behavior analysis when provided by or supervised by a Board Certified Behavior Analyst;
 - (ii) Pharmacy care;
 - (iii) Psychiatric care;
 - (iv) Psychological care;
 - (v) Therapeutic care; and
 - (vi) Equipment determined necessary to provide evidence-based treatment; and
- (B) Any care for an individual with autism spectrum disorder that is determined by a licensed physician to be:
 - (i) Medically necessary; and
 - (ii) Evidence-based.

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

[BENEFITS FOR GASTRIC PACEMAKER

Benefits will be paid the same as any other Sickness for a Gastric Pacemaker and shall be based on Medical Necessity.

Gastric Pacemaker means a medical device that:

- (A) Uses an external programmer and implanted electrical leads to the stomach; and
- (B) Transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat Gastroparesis.

“Gastroparesis” means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

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

PART [IX]
EXCLUSIONS AND LIMITATIONS

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

1. [Acne[, except as specifically provided in the policy];]
2. [Acupuncture[, except as specifically provided in the policy];]
3. [Allergy including allergy testing[, except as specifically provided in the policy];]
4. [[Addiction, such as:] [nicotine addiction, except as specifically provided in the policy;] [and] [caffeine addiction;] [non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious;] [codependency;]]
5. [Assistant Surgeon Fees;]
6. [[hyperkinetic syndromes,] [milieu therapy,] [learning disabilities,] [behavioral problems,] [[parent-child problems,] [attention deficit disorder,] [conceptual handicap,] [developmental delay or disorder or mental retardation,][except as specifically provided in the policy];]
7. [Biofeedback[, except as specifically provided in the policy];]
8. [Durable Medical Equipment;]
9. [Chemotherapy;] [Radiation Therapy;] [Injections;]
10. [Chronic pain disorders;]
11. [Circumcision;]
12. [Congenital conditions[, except as specifically provided for Newborn or adopted Infants;]]
13. [Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy [or for [newborn] [or] [adopted] children;] [except as specifically provided in the policy;]] [removal of [warts,] [non-malignant] [moles] [and] [lesions;] [except as specifically provided in the policy;]]
14. [Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, [college infirmaries] or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;]
15. [Dental treatment[, except [for accidental Injury to [Sound,] Natural Teeth] [as specifically provided in the Schedule of Benefits];]
16. [Elective Surgery or Elective Treatment;]
17. [Elective abortion;]
18. [[Eye examinations,] [eye refractions,] [eyeglasses,] [contact lenses,] [prescriptions or fitting of eyeglasses or contact lenses,] [vision correction surgery,] [or] [other treatment for visual defects and problems]; except when due to a covered Injury or disease process[or except as specifically provided in the policy];]
19. [[Flat foot conditions;] [supportive devices for the foot;] [subluxations of the foot;] [fallen arches;] [weak feet;] [chronic foot strain;] [symptomatic complaints of the feet;] [and] [routine foot care including the care, cutting and removal of [corns,] [calluses,] [toenails,] [and] [bunions (except capsular or bone surgery)];] [except as specifically provided in the policy;]]
20. [Health spa or similar facilities; strengthening programs;]

21. [[Hearing examinations;]; [hearing aids;] [or] [cochlear implants;] [except as specifically provided in the Benefits for Hearing Aids, if elected by the Policyholder;] [or] [except as specifically provided in the policy;] [or] other treatment for hearing defects and problems, except as a result of an infection or trauma, except as specifically provided in the Benefits for the Treatment of Speech and Hearing Disorders. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;]
22. [Hirsutism;] [alopecia;]
23. [Home health care;]
24. [Hospice care;]
25. [Hospital outpatient facility or clinic fee;]
26. [Hypnosis;]
27. [Immunizations, except as specifically provided in the policy;] [preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;]
28. [Injury caused by, contributed to, or resulting from the [addiction to or] use of [alcohol,] [intoxicants,] [hallucinogenics,] [illegal drugs][, or] any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;]
29. [Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;]
30. [Injury or Sickness outside the United States and its possessions[, Canada] [or] [Mexico][, except [for a Medical Emergency] when traveling for [academic study abroad programs] [business] [or] [pleasure];]
31. [Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance [in excess of \$[500 – 20,000]];]
32. [Injury sustained while (a) participating in any [interscholastic,] [high school,] [intramural,] [club,] [or] [intercollegiate,] [or professional] sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;]
33. [Injury sustained while (a) participating in any contest or competition of [intramural football, etc.] [or] [intercollegiate football, etc.]; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;]
34. [Investigational services;]
35. [Lipectomy;]
36. [[Marital] [or] [family] counseling;]
37. [Mental Illness;] [Substance Use Disorders;] [Methadone maintenance treatment for Substance Use Disorders;]
38. [Motor vehicle Injury;]
39. [Organ transplants[, including organ donation];]
40. [[Outpatient] Physiotherapy[; except for a condition that required surgery or Hospital Confinement[: 1) within the [30 - 90] days immediately preceding such Physiotherapy; or 2) within the [30 - 90] days immediately following the attending Physician's release for rehabilitation];] [or when referred by the Student Health Center;]]
41. [Participation in a riot or civil disorder; commission of or attempt to commit a felony; [or fighting;]]

42. [Pre-existing Conditions [in excess of \$[500 – 20,000]][, except for individuals who have been continuously insured under the student association’s [student insurance] policy for at least [12] consecutive months]. [The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy[provided the coverage was continuous to a date within [30 – 120] days prior to the Insured’s effective date under this policy].] This exclusion will not be applied to an Insured Person who is under age 19;]
43. [Prescription Drugs dispensed or purchased while not Hospital Confined[; except when dispensed at the Student Health Center];]
44. [Prescription Drugs, services or supplies as follows[, except as specifically provided in the policy]:
- a) [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;]
 - b) [Birth control and/or contraceptives, oral or other, whether medication or device[, regardless of intended use;] except as specifically provided in Preventive Care Services[or except as specifically provided in the policy;]]
 - c) [Immunization agents, except as specifically provided in the policy,] [biological sera,] [blood or blood products administered on an outpatient basis];
 - d) [Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs;]
 - e) [Products used for cosmetic purposes;]
 - f) [Drugs used to treat or cure baldness;][anabolic steroids used for body building;]
 - g) [Anorectics - drugs used for the purpose of weight control;]
 - h) [Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;]
 - i) [Growth hormones;]
 - j) [Drugs used for tobacco cessation, except as specifically provided in the policy]; [or]
 - k) [Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.]]
45. [Reproductive/Infertility services including but not limited to: [family planning;] [fertility tests;] [infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception;] [premarital examinations;] [impotence, organic or otherwise;] [female sterilization procedures, except as specifically provided in the policy;] [vasectomy;] [sexual reassignment surgery;] [reversal of sterilization procedures;] [except as specifically provided in the policy;]]
46. [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];]
47. [Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;]
48. [[Preventive care services;] [routine physical examinations and routine testing;] [preventive testing or treatment;] [screening exams or testing in the absence of Injury or Sickness;] except as specifically provided in the policy;]
49. [Services provided [normally without charge] by the Health Service of a college or university;] [or] [services covered or provided by a student health fee;]
50. [[Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia;] [temporomandibular joint dysfunction;] [deviated nasal septum, including submucous resection and/or other surgical correction thereof;] [nasal and sinus surgery, except for treatment of a covered Injury[or treatment of chronic purulent sinusitis];] [except as specifically provided in the policy;]]
51. [[Skydiving,] [parachuting,] [hang gliding,] [glider flying,] [parasailing,] [sail planing,] [bungee jumping,] [or] flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; or chartered aircraft only while participating in a school sponsored [intercollegiate sport][activity]];]
52. [Sleep disorders[,except as specifically provided in the policy];]
53. [Speech therapy, except as specifically provided in the Benefits for the Treatment of Speech and Hearing Disorders;] [naturopathic services;]

54. [[Suicide or attempted suicide while sane or insane [(including drug overdose)];] [or] [intentionally self-inflicted Injury];]
55. [Supplies, except as specifically provided in the policy;]
56. [Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, [or gynecomastia;] except as specifically provided in the policy;]
57. [Travel in or upon, sitting in or upon, alighting to or from, or working on or around any [motorcycle [or]] [recreational vehicle including but not limiting to: [two- or three-wheeled] motor vehicle;] [four-wheeled all terrain vehicle (ATV);] [jet ski;] [ski cycle;] [or] [snowmobile;]]]
58. [[Skiing;] [snowboarding;] [scuba diving;] [surfing;] [roller skating;] [skateboarding;] [or] [riding in a rodeo;]]]
59. [Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;]
60. [War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);] and
61. [Weight management, weight reduction, [nutrition programs,] [treatment for obesity,] [(except) [surgery for] morbid obesity)], surgery for removal of excess skin or fat, [and] [treatment of eating disorders such as bulimia and anorexia][, except as specifically provided in the policy]. [Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.]]

**PART [V]
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
[INJURY] [AND] [SICKNESS] BENEFITS**

Maximum Benefit	[\$1,250,000– No Maximum] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
Deductible	[\$0 – 15,000] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
[The Deductible will not be applied until the Company has paid \$[1,000 – 25,000] in Covered Medical Expenses]	[Deductible \$[0 – 45,000] [For all Insureds in a Family, Per Policy Year]]
Coinsurance	[[50 – 100]%] [[50 - 100]% to \$[1,000 – 50,000], then [50 – 100]% thereafter] [[50 – 100]% to \$[1,000 – 25,000], Deductible applies after \$[1,000 – 25,000], then [50 – 100]% thereafter]
[Out-of-Pocket Maximum	[\$[0 - 45,000] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
[Out-of-Pocket Maximum	[\$[0 - 135,000] (For all Insureds in a Family, Per Policy Year)]

[The Company will pay Covered Medical Expenses incurred at [50 - 100%] up to \$[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the \$[500 – 10,000] Deductible. After the Company pays \$[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at [50 100]% not to exceed the Maximum Benefit [of \$[1,250,000].]

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

[Student Health Center Benefits: [The Deductible will be waived] [and] [benefits will be paid at [100%] [for Covered Medical Expenses incurred] [of billed charges] when treatment is rendered at [or referred by] the Student Health Center] [for the following services: [e.g., any services listed in the schedule of benefits].]

[Per Service Deductibles: All per service Deductibles specified in the Schedule of Benefits are in addition to the policy Deductible.]

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto.

Inpatient

Room & Board:	[\$[100 – 2,000] Deductible [per day] [per Hospital Confinement]] [Usual and Customary Charges] [[30 – 365] days maximum [per Policy Year] [per Hospital Confinement] [for each [Injury] [or] [Sickness]]] [No Benefits]
[Intensive Care:	[\$[100 – 2,000] Deductible [per day] [per Hospital Confinement]] [Usual and Customary Charges] [Paid under Room & Board] [[30 – 365] days maximum [per Policy Year] [per Hospital Confinement] [for each [Injury] [or] [Sickness]]]
Hospital Miscellaneous:	[Usual and Customary Charges] [Paid under Room & Board] [No Benefits]
[Routine Newborn Care:	[Paid as any other Sickness] [Usual and Customary Charges] [No Benefits]
[Physiotherapy:	[Usual and Customary Charges] [Paid under Hospital Miscellaneous] [No Benefits]

Surgery: [Usual and Customary Charges]
[No Benefits]

[Assistant Surgeon: [[25 – 50]% of Surgery Allowance]
[Usual and Customary Charges]
[No Benefits]]

Anesthetist: [[25 – 50]% of Surgery Allowance]
[Usual and Customary Charges]
[No Benefits]

Registered Nurse: [Usual and Customary Charges]
[[10 – 365] days maximum [per Policy Year] [for each [Injury] [or] [Sickness]]
[No Benefits]]

Physician's Visits: [\\$[25 – 250] Deductible [per visit] [per service]]
[Usual and Customary Charges]
[No Benefits]

Pre-admission Testing: [Usual and Customary Charges]
[Paid under Hospital Miscellaneous]
[No Benefits]

Outpatient

Surgery: [Usual and Customary Charges]
[No Benefits]

Day Surgery Miscellaneous: [\\$[10 – 1000] Deductible [per date of service]]
[Usual and Customary Charges]
[No Benefits]

(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)

[Assistant Surgeon: [[25 – 50]% of Surgery Allowance]
[Usual and Customary Charges]
[No Benefits]]

Anesthetist: [Usual and Customary Charges]
[[25 – 50]% of Surgery Allowance]
[No Benefits]

Physician's Visits: [\\$[5 – 100] Deductible per visit]
[Usual and Customary Charges]
[[5 – 100] [days] [visits] maximum [per Policy Year] [for each [Injury] [or] [Sickness]]]

[Physiotherapy: [Paid under Physician's Visits]
[\\$[5 – 100] Deductible per visit]
[Usual and Customary Charges]
[[5 – 160] [days] [visits] maximum [per Policy Year] [for each [Injury] [or] [Sickness]]]
[No Benefits]
See also Benefits for the Treatment of Speech and Hearing Disorders
[[Outpatient Physiotherapy benefits are payable only [when referred by the Student Health Center or] for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.]]]

Medical Emergency: [\\$[5 – 750] Deductible per visit]
[Usual and Customary Charges]
[(The Deductible will be waived if admitted to the Hospital.)]

X-Rays: [\\$[5 – 100] Deductible [per service] [per visit]]
[Usual and Customary Charges]
[No Benefits]

[Radiation Therapy: [\\$[5 – 100] Deductible [per service] [per visit]]
[Usual and Customary Charges]
[No Benefits]]

Laboratory: [\\$[5 – 100] Deductible [per service] [per visit]]
[Usual and Customary Charges]
[No Benefits]

Tests & Procedures: [\\$[5 – 100] Deductible [per service] [per visit]]
[Usual and Customary Charges]
[No Benefits]

[Injections: [\\$[5 – 50] Deductible [per injection] [per visit]]
[Usual and Customary Charges]
[No Benefits]]

[Chemotherapy: [\$5 – 50] Deductible per treatment]
 [Usual and Customary Charges]
 [No Benefits]]

Prescription Drugs: [No Benefits]
 [Usual and Customary Charges]
 [See Below]

 [*[UnitedHealthcare Network Pharmacy [(UHPS)]: [\$50 – 1,000] Deductible (per Policy Year) (does not apply to policy Deductible)] [[\$0-650] Copay per prescription] [50 -100]% Coinsurance per prescription] [tier 1] [tier 2] [tier 3] [tier 4] [in addition to the Policy Deductible,] [plus any Ancillary Charge] / [up to a [31][60] day supply [per prescription] [per Specialty Prescription Drug Product]]]

 [*Mail order [through UHPS] [at [2 - 2.5] times the retail Copay] [\$50 – 1,000] Deductible (per Policy Year) (does not apply to policy Deductible)] [[\$25-1,950] Copay per prescription] [50 -100]% Coinsurance per prescription] [tier 1] [tier 2] [tier 3] [tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge] [up to a [90] day supply]]

 [Out-of-Network Pharmacy: [\$50 – 1,000] Deductible (per Policy Year) (does not apply to policy Deductible)] [[\$10-450] Deductible per prescription [generic drug] [brand-name drug] [in addition to the policy Deductible]] [up to a [31] day supply [per prescription]] [[50 – 100]% [of] [Usual and Customary Charges]] [No Benefits]]

 [Prescription Drugs for tobacco cessation are limited to \$[200 – 1000] maximum per Policy Year]

Other

Ambulance: [\$25 – 1000] Deductible [per trip] [per day] [ground] [air]]
 [Usual and Customary Charges]
 [No Benefits]]

[Durable Medical Equipment: [\$5 – 500] Deductible [per purchase]]
 [Benefits payable under the [\$500] [Usual and Customary Charges]
 maximum are not included in the [\$500 – 100,000] maximum [per Policy Year] [for each [Injury] [or] [Sickness]]
 [\$1,250,000] Maximum Benefit.] [No Benefits]]

See also Benefits for Orthotic and
 Prosthetic Devices and Services

[Consultant: [\$5 – 100] Deductible per [outpatient] visit]
 [Usual and Customary Charges]
 [[5 – 100] [days] [outpatient] [visits] maximum [per Policy Year]
 [for each [Injury] [or] [Sickness]]
 [No Benefits]]

[Dental: [\$5 – 75] Deductible [per tooth] [per visit]]
 [Dental benefits are not subject to [\$50 – 500] per tooth] [/] [\$100 – 5,000] maximum]
 the [\$1,250,000] Maximum Benefit.] [per Policy Year] [for each Injury]
 [Usual and Customary Charges]
 [Paid as any other Injury]
 [No Benefits]]

 (Benefits paid on Injury to Sound, Natural Teeth only.)

[Dental: [\$5 – 100] Deductible [per tooth] [per visit]]
 [Usual and Customary Charges]
 [\$50 – 1,500] maximum [per procedure] [per tooth]]
 [No Benefits]]

 (Benefits paid for removal of impacted wisdom teeth only.)

[Mental Illness Treatment: Paid as any other Sickness]

[Substance Use Disorder Treatment: Paid as any other Sickness]
 [Maternity [Paid as any other Sickness]]

[Elective Abortion: [\$5 – 100] Deductible per procedure]
 [Usual and Customary Charges]
 [\$100 – 1,000] maximum [per Policy Year]
 [No Benefits]]

 (Elective Abortion benefits are not subject to the [\$1,250,000] Maximum Benefit.)

[Complications of Pregnancy: Paid as any other Sickness]

[Preventive Care Services: [100% of Usual and Customary Charges]
 (No Deductible or Coinsurance will be applied to Preventive Care Services.)]

[Reconstructive Surgery
 Following Mastectomy: Paid as any other Sickness / See Benefits for Mastectomy and Reconstructive Breast
 Surgery]

[Diabetes Services: Paid as any other Sickness / See Benefits for Diabetes]

[High Cost Procedures:	[\$5 – 500] Deductible [per procedure] [per service]] [Usual and Customary Charges] [No Benefits]]
[Home Health Care:	[\$5 – 50] Deductible per visit] [Usual and Customary Charges] [[40 – 200] visits maximum [per Policy Year]] [No Benefits]]
[Hospice Care:	[\$5 – 100] Deductible [per day]] [Usual and Customary Charges] [\$1,000 – 10,000] maximum benefit] [[40 – 180] days maximum [per Policy Year]] [Paid as any other Sickness / [If elected by the Policyholder] See Benefits for Hospice Care] [No Benefits]]
	[(Hospice Care benefits are not subject to the [\$1,250,000] Maximum Benefit.)]
[Inpatient Rehabilitation Facility:	[\$50 – 1,000] Deductible per day] [\$50 – 2,000] Deductible per Inpatient admission] [Usual and Customary Charges] [[30 – 180] days maximum [per Policy Year] [total combined benefit with Skilled Nursing Facility benefits.]] [No Benefits]]
[Skilled Nursing Facility:	[\$50 – 1,000] Deductible per day] [\$50 – 2,000] Deductible per Inpatient admission] [Usual and Customary Charges] [[30 – 180] days maximum [per Policy Year] [total combined benefit with Inpatient Rehabilitation Facility benefits]] [No Benefits]]
[Urgent Care Center:	[\$5 – 150] Deductible per visit] [Usual and Customary Charges] [[10 – 100] [days] [visits] maximum [per Policy Year] [for each [Injury] [or] [Sickness]]]
	[No Benefits]]
[Hospital Outpatient Facility or Clinic:	[\$5 – 150] Deductible per visit] [Usual and Customary Charges] [No Benefits]]
[Approved Clinical Trials: [Repatriation:	[Paid as any other Sickness]] [\$500 – 25,000] maximum] [Benefits provided by Scholastic Emergency Services, Inc.] [No Benefits]]
[Medical Evacuation:	[\$500 – 25,000] maximum] [Benefits provided by Scholastic Emergency Services, Inc.] [No Benefits]]
[*AD&D:	[\$500 – 25,000] maximum] [No Benefits]]
[Insert any service excluded under the policy (e.g. Acne, Allergy, Organ Transplants)	[\$5 – 2,000] Deductible [per] [visit] [procedure] [service]] [Usual and Customary Charges] [Paid as any other Sickness]]
[Insert any non-essential service excluded under the policy (e.g. acupuncture, infertility, hearing aids, obesity, TMJ, eye exams): [e.g. Acupuncture]	benefits are not subject to the [\$1,250,000] Maximum Benefit.
	[\$5 – 2,000] Deductible [per] [visit] [procedure] [service]] [Usual and Customary Charges] [Paid as any other Sickness] [[10 – 100] [days] [visits] maximum] [[[\$50 – 10,000] maximum] [per Policy Year][for each [Injury] [or] [Sickness]]]

[Continuation Permitted: Yes () No (X)]

[*Pre-Admission Notification: Yes () No (X)]

[() 52 week Benefit Period] [or] [(X) Extension of Benefits]

Other Insurance: (X) *[Excess Insurance] [Coordination of Benefits] () Excess Motor Vehicle [Only] () Primary Insurance

[*If benefit is designated, see endorsement attached.]

PART [V]
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
[INJURY] [AND] [SICKNESS] BENEFITS

Maximum Benefit	[\$1,250,000– No Maximum] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
Deductible [Preferred Provider]	[\$0 - 15,000] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
	[The Deductible will not be applied until the Company has paid \$[1,000 – 25,000] in Covered Medical Expenses.]
[Deductible [Preferred Provider]	[\$0 - 45,000] (For all Insureds in a Family, Per Policy Year)]
[Deductible [Out-of-Network]	[\$0 - 15,000] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
	[The Deductible will not be applied until the Company has paid \$[1,000 – 25,000] in Covered Medical Expenses.]
[Deductible [Out-of-Network]	[\$0 - 45,000] (For all Insureds in a Family, Per Policy Year)]
Coinsurance [Preferred Provider]	[[50 – 100]%] [[50 - 100]% to \$[1,000 – 50,000], then [50 - 100%] thereafter] [[50 – 100]% to \$[1,000 – 25,000], Deductible applies after \$[1,000 – 25,000], then [50 – 100]% thereafter]
Coinsurance [Out-of-Network]	[[50 – 100]%] [[50 - 100]% to \$[1,000 – 50,000], then [50 – 100%] thereafter] [[50 – 100]% to \$[1,000 – 25,000], Deductible applies after \$[1,000 – 25,000], then [50 – 100]% thereafter]
[Out-of-Pocket Maximum [Preferred Provider]	[\$0 - 45,000] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
[Out-of-Pocket Maximum [Preferred Provider]	[\$0 - 135,000] (For all Insureds in a Family, Per Policy Year)]
[Out-of-Pocket Maximum [Out-of-Network]	[\$0 - 45,000] [(Per Insured Person, Per Policy Year)] [(For each [Injury] [or] [Sickness])]
[Out-of-Pocket Maximum [Out-of-Network]	[\$0 - 135,000] (For all Insureds in a Family, Per Policy Year)]

[The Company will pay Covered Medical Expenses incurred at [50 – 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers up to \$[1,000 – 25,000] before the Insured Person is responsible for satisfaction of the \$[500 – 10,000] [Preferred Provider] Deductible [and \$[500 – 10,000] Out-of-Network Deductible]. After the Company pays \$[1,000 – 25,000], the Deductible must be satisfied by the Insured Person before additional benefits will be paid. Once the Deductible has been satisfied, the Company will pay Covered Medical Expenses incurred at [50 - 100]% for Preferred Providers and [50 – 100]% for Out-of-Network Providers not to exceed the Maximum Benefit [of \$[1,250,000].]

The Preferred Provider for this plan is [University Hospital] [UnitedHealthcare Options PPO].

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. [If a Preferred Provider is not available in the Network Area, benefits will be paid at the level of benefits shown as Preferred Provider benefits.] If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. [Covered Medical Expense incurred at a Preferred Provider facility by an Out-of-Network Provider will be paid at the Preferred Provider level of benefits.] [Except for a Medical Emergency, Covered Medical Expenses incurred at a Preferred Provider facility by an Out-of-Network provider will be paid at the Out-of-Network level of benefits.] [In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.]

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

Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays[and per service Deductibles].]

[Student Health Center Benefits: [The Deductible will be waived] [and] [benefits will be paid at [100%] [for Covered Medical Expenses incurred] [of billed charges] when treatment is rendered at [or referred by] the Student Health Center] [for the following services: [e.g., any services listed in the schedule of benefits].]

[Copays and Per Service Deductibles: All Copays [and per service Deductibles] specified in the Schedule of Benefits are in addition to the policy Deductible.]

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. [All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated.]

Inpatient	Preferred Provider	Out-of-Network
Room & Board: [[30 – 365] days maximum [per Policy Year] [per Hospital Confinement][for each [Injury] [or] [Sickness]]]	[\$[100 – 1,000] Copay per day [to a maximum Copay of \$[100 – 10,000] per Hospital Confinement]] [\$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [No Benefits]	[\$[100 – 2,000] Deductible [per day] [per Hospital Confinement]] [[100 – 50]% of] [Usual and Customary Charges] [No Benefits]
[Intensive Care: [[30 – 365] days maximum [per Policy Year] [per Hospital Confinement] [for each [Injury] [or] [Sickness]]]	[\$[100 – 1,000] Copay per day [to a maximum Copay of \$[100 – 10,000] per Hospital Confinement]] [\$[100 – 2,000] Copay per Hospital Confinement] [[50-100]% of] [Preferred Allowance] [No Benefits]	[\$[100 – 2,000] Deductible [per day] [per Hospital Confinement]] [[50-100]% of] [Usual and Customary Charges]
Hospital Miscellaneous:	[[50-100]% of] [Preferred Allowance] [No Benefits]	[[50-100]% of] [Usual and Customary Charges] [No Benefits]
[Routine Newborn Care:	[Paid as any other Sickness] [[50-100]% of] [Preferred Allowance] [No Benefits]	[Paid as any other Sickness] [[50-100]% of] [Usual and Customary Charges] [No Benefits]
[Physiotherapy:	[Paid under Hospital Miscellaneous] [[50-100]% of] [Preferred Allowance] [No Benefits]	[Paid under Hospital Miscellaneous] [[50-100]% of] [Usual and Customary Charges] [No Benefits]
Surgery:	[[50-100]% of] [Preferred Allowance] [No Benefits]	[[50-100]% of] [Usual and Customary Charges] [No Benefits]
[Assistant Surgeon:	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [No Benefits]	[[50-100]% of] [Usual and Customary Charges] [[25 - 50]% of surgery allowance] [No Benefits]
Anesthetist:	[[50-100]% of] [Preferred Allowance] [[25 - 50]% of surgery allowance] [No Benefits]	[50-100]% of] [Usual and Customary Charges] [[25 – 50]% of surgery allowance] [No Benefits]
Registered Nurse’s Services: [[10 – 365] days maximum [per Policy Year] [for each [Injury] [or] [Sickness]]]	[[50-100]% of] [Preferred Allowance] [No Benefits]	[[50-100]% of] [Usual and Customary Charges] [No Benefits]
Physician’s Visits:	[\$[25 – 250] Copay [per visit] [per service]] [[50-100]% of] [Preferred Allowance] [No Benefits]	[\$[25 – 250] Deductible [per visit] [per service]] [[50-100]% of] [Usual and Customary Charges] [No Benefits]
Pre-admission Testing:	[Paid under Hospital Miscellaneous]	[Paid under Hospital Miscellaneous]

[[50-100]% of] [Preferred Allowance]
[No Benefits]

[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

Outpatient

Surgery:

[[50-100]% of] [Preferred Allowance]
[No Benefits]

[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

Day Surgery Miscellaneous:

[\$[10 – 1,000] Copay [per date of
service]]
[[50-100]% of] [Preferred Allowance]
[No Benefits]

[\$[10 – 1,000] Deductible [per date
of service]]
[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

[(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)]

Assistant Surgeon:

[[50-100]% of] [Preferred Allowance]
[[25 - 50]% of surgery allowance]
[No Benefits]

[[50-100]% of] [Usual and
Customary Charges]
[[25 - 50]% of surgery allowance]
[No Benefits]

Anesthetist:

[[50-100]% of] [Preferred Allowance]
[[25 - 50]% of surgery allowance]
[No Benefits]

[[50-100]% of] [Usual and
Customary Charges]
[[25 - 50]% of surgery allowance]
[No Benefits]

Physician's Visits:

[[5 – 100] [days][visits] maximum [per
Policy Year] [for each [Injury] [or]
[Sickness]]]

[\$[5 – 100] Copay per visit]
[[50-100]% of] [Preferred Allowance]

[\$[5 – 100] Deductible per visit]
[[50-100]% of] [Usual and
Customary Charges]

Physiotherapy:

[[Preferred Provider] [Out-of-Network] [is
limited to] [5 – 160] [days][visits] maximum
[per Policy Year] [for each [Injury] [or]
[Sickness]] See also Benefits for the
Treatment of Speech and Hearing Disorders]

[\$[5 – 100] Copay per visit]
[[50-100]% of] [Preferred Allowance]
[No Benefits]

[\$[5 – 100] Deductible per visit]
[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

[(Outpatient Physiotherapy benefits are payable only [when referred by the Student Health Center or] for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation.)]

Medical Emergency:

[(The [Copay][/] [per visit Deductible] will
be waived if admitted to the Hospital.)]

[\$[5 – 500] Copay per visit]
[[50-100]% of] [Preferred Allowance]

[\$[5 – 750] Deductible per visit]
[[50-100]% of] [Usual and
Customary Charges]

X-rays:

[\$[5 – 100] Copay [per service] [per
visit]]
[[50-100]% of] [Preferred Allowance]
[No Benefits]

[\$[5 – 100] Deductible [per service]
[per visit]]
[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

Radiation Therapy:

[\$[5 – 100] Copay per treatment]
[[50-100]% of] [Preferred Allowance]
[No Benefits]

[\$[5 – 100] Deductible per
treatment]
[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

Laboratory:

[\$[5 – 100] Copay [per service] [per
visit]]
[[50-100]% of] [Preferred Allowance]
[No Benefits]

[\$[5 – 100] Deductible [per service]
[per visit]]
[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

Tests and Procedures:

[\$[5 – 500] Copay [per service] [per
visit]]
[[50-100]% of] [Preferred Allowance]
[No Benefits]

[\$[5 – 500] Deductible [per service]
[per visit]]
[[50-100]% of] [Usual and
Customary Charges]
[No Benefits]

Injections:

[\$[5 – 50] Copay [per injection] [per

[\$[5 – 50] Deductible [per injection]

	visit]] [[50-100]% of] [Preferred Allowance] [No Benefits]	[per visit]] [[50-100]% of] [Usual and Customary Charges] [No Benefits]]
[Chemotherapy:	[\$5 – 100] Copay per treatment [[50-100]% of] [Preferred Allowance] [No Benefits]	[\$5 – 100] Deductible per treatment [[50-100]% of] [Usual and Customary Charges] [No Benefits]]
[Prescription Drugs: [Prescription Drugs for tobacco cessation are limited to \$200 - 1000] maximum per Policy Year.] [*Mail order Prescription Drugs [through [UHPS]] [at [2 - 2.5] times the retail Copay] [\$50 – 1,000] Deductible (per Policy Year) [does not apply to policy Deductible]] [[50 - \$1,950] Copay per prescription] [[50 - 100]% Coinsurance per prescription] [tier 1] [tier 2] [tier 3] [tier 4]] [in addition to the Policy Deductible] [plus any Ancillary Charge] [up to a [90] day supply]]	[* [UnitedHealthcare Network Pharmacy ((UHPS),)] [\$50 – 1,000] Deductible (per Policy Year) [does not apply to policy Deductible]] [[50-650] Copay per prescription] [[50 -100]% Coinsurance per prescription] [tier 1] [tier 2] [tier 3] [tier 4] [in addition to the Policy Deductible,] [plus any Ancillary Charge] / [up to a [31][60] day supply [per prescription] [per Specialty Prescription Drug Product]]] [No Benefits]	[\$50 – 1,000] Deductible (per Policy Year) [does not apply to policy Deductible]] [\$0-450] Deductible per prescription [generic drug] [brand-name drug] [in addition to the policy Deductible] [up to a [31]-day supply [per prescription]] [[50-100]% of] [Usual and Customary Charges] [No Benefits]]

Other

Ambulance:	[\$25 – 1000] Copay [per trip][per day] [ground][air]] [[50-100]% of] [Preferred Allowance] [No Benefits]	[\$25 – 1000] Deductible [per trip][per day] [ground][air]] [[50-100]% of] [Usual and Customary Charges] [No Benefits]
[Durable Medical Equipment: [\$500 -100,000] maximum [per Policy Year] [for each [Injury] [or] [Sickness]] See also Benefits for Orthotic and Prosthetic Devices and Services [Durable Medical Equipment benefits payable under the \$500 – 100,000] maximum are not included in the [\$1,250,000] Maximum Benefit.]	[\$5 – 500] Copay [per purchase]] [[50-100]% of] [Preferred Allowance] [No Benefits]	[\$5 – 500] Deductible [per purchase]] [[50-100]% of] [Usual and Customary Charges] [No Benefits]]
[Consultant: [[5 – 100] [days] [outpatient] [visits] maximum [per Policy Year] [for each [Injury] [or] [Sickness]]]	[\$5 – 100] Copay per [outpatient] visit]] [[50-100]% of] [Preferred Allowance] [No Benefits]	[\$5 – 100] Deductible per [outpatient] visit]] [[50-100]% of] [Usual and Customary Charges] [No Benefits]]
[Dental: [\$50 – 1,500] per tooth] / [\$100 - 5,000] maximum] [per Policy Year] [for each Injury] Benefits paid on Injury to Sound, Natural Teeth only. [Benefits are not subject to the [\$100,000] Maximum Benefit.]	[\$5 – 75] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance] [Paid as any other Injury] [No Benefits]	[\$5 – 75] Deductible [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges] [Paid as any other Injury] [No Benefits]]
[Dental: [\$50 – 1,500] maximum per procedure] Benefits paid for removal of impacted wisdom teeth only.	[\$5 – 100] Copay [per tooth] [per visit]] [[50-100]% of] [Preferred Allowance]	[\$5 – 100] Deductible [per tooth] [per visit]] [[50-100]% of] [Usual and Customary Charges]
[Mental Illness Treatment:	Paid as any other Sickness	Paid as any other Sickness]
[Substance Use Disorder Treatment: COL-12A-AR SOB PPO	Paid as any other Sickness	Paid as any other Sickness]

[Maternity:	[Paid as any other Sickness]	[Paid as any other Sickness]]
[Elective Abortion:	[\$[5 – 100] Copay per procedure]	[\$[5 – 100] Deductible per
[\$[100 – 1000] maximum] [per Policy Year]	[[50-100]% of] [Preferred Allowance]	procedure]
[Elective Abortion benefits are not subject to	[No Benefits]	[[50-100]% of] [Usual and
the [\$1,250,000] Maximum Benefit.]		Customary Charges]
		[No Benefits]]
[Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness]
[Preventive Care Services:	100% of Preferred Allowance	[\$[5 – 100] Copay [per visit] [per
No Deductible, Copays or Coinsurance will		service]]
be applied when the services are received		[[50-100]% of] [Usual and
from a Preferred Provider.		Customary Charges]
		[No Benefits]]
[Reconstructive Breast Surgery Following	Paid as any other Sickness	Paid as any other Sickness]
Mastectomy: See Benefits for Mastectomy		
and Reconstructive Breast Surgery		
[Diabetes Services: See Benefits for	Paid as any other Sickness	Paid as any other Sickness]
Diabetes		
[High Cost Procedures:	[\$[5 – 500] Copay [per procedure] [per	[\$[5 – 500] Deductible [per
	service]]	procedure] [per service]]
	[[50-100]% of] [Preferred Allowance]	[[50-100]% of] [Usual and
	[No Benefits]	Customary Charges]
		[No Benefits]]
[Home Health Care:	[\$[5 – 50] Copay per visit]	[\$[5 – 50] Deductible per visit]
[[40 – 200] visits maximum [per Policy	[[50-100]% of] [Preferred Allowance]	[[50-100]% of] [Usual and
Year]]	[No Benefits]	Customary Charges]
		[No Benefits]]
[Hospice Care: [\$[1,000 – 10,000]	[\$[5 – 100] Copay [per day]]	[\$[5 – 100] Deductible [per day]]
maximum benefit] [[40 – 180] days	[[50-100]% of] [Preferred Allowance]	[[50-100]% of] [Usual and
maximum] [per Policy Year]	[Paid as any other Sickness]	Customary Charges]
[Hospice Care benefits are not subject to the	[No Benefits]	[Paid as any other Sickness]
[\$1,250,000] Maximum Benefit.] [[If elected		[No Benefits]]
by the Policyholder] See Benefits for		
Hospice Care]		
[Inpatient Rehabilitation Facility:	[\$[50 – 1,000] Copay per day [to a	[\$[50 – 1,000] Deductible per day]
[[30 – 180] days maximum [per Policy Year]	maximum Copay of \$[50 – 10,000] per	[\$[50 – 2,000] Deductible per
[total combined benefit with Skilled Nursing	Inpatient admission]]	Inpatient admission]
Facility benefits]]	[\$[50 – 2,000] Copay per Inpatient	[[50-100]% of] [Usual and
	admission]	Customary Charges]
	[[50-100]% of] [Preferred Allowance]	[No Benefits]]
	[No Benefits]	
[Skilled Nursing Facility:	[\$[50 – 1,000] Copay per day [to a	[\$[50 – 1,000] Deductible per day]
[[30 – 180] days maximum [per Policy Year]	maximum Copay of \$[50 – 10,000] per	[\$[50 – 2,000] Deductible per
[total combined benefit with Inpatient	Inpatient admission]]	Inpatient Admission]
Rehabilitation Facility benefits]]	[\$[50 – 2,000] Copay per Inpatient	[[50-100]% of] [Usual and
	Admission]	Customary Charges]
	[[50-100]% of] [Preferred Allowance]	[No Benefits]]
	[No Benefits]	
[Urgent Care Center:	[\$[5 – 150] Copay per visit]	[\$[5 – 150] Deductible per visit]
[[10 – 100] [days][visits] maximum [per	[[50-100]% of] [Preferred Allowance]	[[50-100]% of] [Usual and
Policy Year] [for each [Injury] [or]	[No Benefits]	Customary Charges]
[Sickness]]]		[No Benefits]]
[Hospital Outpatient Facility or Clinic:	[\$[5 – 150] Copay per visit]	[\$[5 – 150] Deductible per visit]
	[[50-100]% of] [Preferred Allowance]	[[50-100]% of] [Usual and
	[No Benefits]	Customary Charges]
		[No Benefits]]
[Approved Clinical Trials:	[Paid as any other Sickness]	[Paid as an y other Sickness]
	[No Benefits]	[No Benefits]]
[Repatriation: [\$[500 – 25,000] maximum]	N/A	N/A]

[Benefits provided by [Scholastic Emergency Services, Inc.]]

[Medical Evacuation: [\$500 - 25,000] maximum] [Benefits provided by [Scholastic Emergency Services, Inc.]]

N/A

N/A

[*AD&D: [\$500 - 25,000] maximum]

N/A

N/A

[Insert any service excluded under the policy (e.g. Acne, Allergy, Organ Transplants)

[Paid as any other Sickness]
[\$[5 – 2000] Copay [per] [visit]
[procedure] [service]]
[[50-100]% of] [Preferred Allowance]

[Paid as any other Sickness]
[\$[5 – 2000] Deductible [per] [visit]
[procedure] [service]]
[[50-100]% of] [Usual and
Customary Charges]]

[[10 – 100] [days][visits] maximum [per
Policy Year] [for each [Injury] [or]
[Sickness]]]

[Insert any non-essential service excluded under the policy (e.g. acupuncture, infertility, hearing aids, obesity, TMJ, eye exams) [[10 – 100] [days] [visits] maximum] [[[\$50 – 10,000] maximum] [per Policy Year][for each [Injury] [or] [Sickness]]] [e.g. Acupuncture] benefits are not subject to the [\$1,250,000] Maximum Benefit.]

[Paid as any other Sickness]
[\$[5 – 2000] Copay [per] [visit]
[procedure] [service]]
[[50-100]% of] [Preferred Allowance]

[Paid as any other]
[\$[5 – 2000] Deductible [per] [visit]
[procedure] [service]]
[[50-100]% of] [Usual and
Customary Charges]]

[Continuation Permitted: Yes () No (X)]

[*Pre-Admission Notification: Yes () No (X)]

[() 52 week Benefit Period] [or] [(X) Extension of Benefits]

Other Insurance: (X) ***[Excess Insurance][Coord. of Benefits]** () **Excess Motor Vehicle [Only]** () **Primary Insurance**

[*If benefit is designated, see endorsement attached.]

Policyholder Application

UnitedHealthcare StudentResources

UnitedHealthcare Insurance Company P.O. Box 809025 Dallas, TX 75380-9025

Policyholder	[Any Student Association]	Date	[00-00-00]
Mailing Address	[Any Town,]	Policy Number	[00-0000-00]
		Effective	[2012 / 2013]
			Academic Year
Telephone Number	[(555) 555-5555]		

Class of Persons to be Insured

[Any Student] [and their eligible Dependents]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rates

[Annual]
[Student] [\$1,200.00]

Effective / Expiration Dates

(Information continues on attached sheets.)

Signature of Association Official _____ Title _____ Date _____

Please Print Name of Above Official _____

Signature of Agent _____ Date _____

Signature of Company Representative _____ Title _____ Date _____

Policyholder Application (Continued)
UnitedHealthcare StudentResources
UnitedHealthcare Insurance Company
Arkansas Mandatory Offers of Coverage

I hereby _____ elect _____ decline the Mammography coverage as offered according to the Arkansas Insurance Code.

I hereby _____ elect _____ decline the Temporomandibular Joint Disorder Treatment Benefit coverage as offered according to Arkansas Insurance Code.

I hereby _____ elect _____ decline the Hospice Care Benefit coverage as offered according to Arkansas Insurance Code.

I hereby _____ elect _____ decline the Hearing Aid coverage as offered according to Arkansas Insurance Code.

I hereby elect or decline that identical coverage be provided on an Outpatient basis if such coverage is provided on an Inpatient basis for any of the following services as offered according to the Arkansas Insurance Code.

Elect	Decline	
_____	_____	Laboratory & Pathological Tests
_____	_____	X-Rays
_____	_____	Chemotherapy
_____	_____	Radiation Therapy
_____	_____	Renal Dialysis

Signature of Student Association Official _____

Title _____

Date _____

POLICY ENDORSEMENT

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

EXCESS PROVISION [INJURY ONLY] [SICKNESS ONLY]

No benefit of this policy is payable for any expense incurred for [Injury] [or] [Sickness] which is paid or payable by[: 1)] other valid and collectible [group] insurance[; or, 2) under an automobile insurance policy]. All premium must be paid by the Policyholder.

[This Excess Provision will not be applied to the first \$[100 - \$10,000] of medical expenses incurred.]

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

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

POLICY ENDORSEMENT

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

**EXCESS PROVISION
HOSPITAL CONFINEMENT [/ SURGERY] ONLY
[INJURY ONLY] [SICKNESS ONLY]**

When[: 1)] the Insured is Hospital Confined;[or 2) surgery is performed,] no benefit of this policy is payable for any expense incurred [for Injury] [for Sickness] which is paid or payable by[: 1)] other valid and collectible [group] insurance[: or 2) under an automobile insurance policy]. All premium must be paid by the Policyholder.

[This Excess Provision will not be applied to the first \$[100 – 10,000] of medical expenses incurred.]

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

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

POLICY ENDORSEMENT

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

COORDINATION OF BENEFITS PROVISION

Definitions

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

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

- (2) **Plan:** A form of coverage with which coordination is allowed.

Plan includes all of the following:

- (a) Group insurance contracts and subscriber contracts.
- (b) Uninsured arrangements of group or group-type coverage.
- (c) Group coverage through closed panel plans.
- (d) Group-type contracts, including blanket contracts.
- (e) The medical care components of long-term care contracts, such as skilled nursing care.
- (f) The medical benefits coverage in automobile no fault and traditional automobile fault type contracts.
- (g) Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

Plan does not include any of the following:

- (a) Hospital indemnity coverage benefits or other fixed indemnity coverage.
 - (b) Accident only coverage.
 - (c) Limited benefit health coverage as defined by state law.
 - (d) Specified disease or specified accident coverage.
 - (e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;
 - (f) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
 - (g) Medicare supplement policies.
 - (h) State Plans under Medicaid.
 - (i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
 - (j) An Individual Health Insurance Contract.
- (3) **Primary Plan:** A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a primary plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.
- (4) **Secondary Plan:** A Plan that is not the Primary Plan.
- (5) **We, Us or Our:** The Company named in the policy to which this endorsement is attached.

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

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

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

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

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

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

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

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

(2) Dependent Child/Parents Married or Living Together. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:

- (a) the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.
- (b) However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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

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

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

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

If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:

- (a) First, the Plan of the parent with custody of the child.
- (b) Then Plan of the spouse of the parent with the custody of the child.
- (c) The Plan of the parent not having custody of the child.
- (d) Finally, the Plan of the spouse of the parent not having custody of the child.

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

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

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

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

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

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

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

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

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

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

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

POLICY ENDORSEMENT

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within [90 - 365] days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the "Medical Expense Benefits" provision.

For Loss Of:

[Life	[\$500 - 25,000.00]
Both Hands, Both Feet, or Sight of Both Eyes	[\$500 - 25,000.00]
One Hand [and] One Foot	[\$500 - 25,000.00]
Either One Hand or One Foot and Sight of One Eye	[\$500 - 25,000.00]
One Hand or One Foot or Sight of One Eye	[\$500 - 25,000.00]
[Entire Thumb and Index Finger of Either Hand	[\$500 - 25,000.00]]

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

[Life	[\$500 - 25,000.00]
Two or More Members	[\$500 - 25,000.00]
One Member	[\$500 - 25,000.00]
[Thumb or Index Finger	[\$500 - 25,000.00]]

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

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

POLICY ENDORSEMENT

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

[ACCIDENTAL] DEATH BENEFIT

If an accidental Injury should independently of all other causes [and within [90 - 365] days from the date of Injury solely] result in the loss of the Insured's life, [or if a covered Sickness should result in the loss of the Insured's life,] the Insured's beneficiary may request the Company to pay \$[500 – 25,000] in addition to payment under any "Medical Expense Benefit" provision.

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.

COL-12A END (6E)

POLICY ENDORSEMENT

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

PRE-ADMISSION NOTIFICATION

[The Monitoring Company] 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.

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

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

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

POLICY ENDORSEMENT

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

DENTAL BENEFITS

Benefits will be paid for the following specific procedures. Payment will not exceed [the maximum amount specified for each procedure]

[E]

[E] = Any dental procedure or service listed in the "Code for Most Frequently Reported Dental Procedures" published by the Journal of the American Dental Association.

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.

COL-12A END (12)

POLICY ENDORSEMENT

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

LIVE ORGAN OR BONE MARROW DONOR BENEFITS

Benefits are payable for the Covered Medical Expenses incurred for a live organ or bone marrow donor for those costs that are directly related to the organ removal or bone marrow donation for a recipient who is an Insured Person under the policy. Benefits are subject to all terms and conditions of the Policy and the provisions of this Endorsement.

Benefits payable for the live organ or bone marrow donor shall be secondary to any other insurance plan, service plan, self-funded group plan, or any governmental plan that does not require this Policy to be primary.

[Benefits are subject to the Insured organ recipient's policy Maximum Benefits under the policy.] [Maximum benefits shall not exceed \$[5,000 – 25,000]].

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

POLICY ENDORSEMENT

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

CONTINUATION PRIVILEGE

All Insured Persons who have been continuously insured under the student association's regular student policy for at least [3 - 12] [consecutive months][one semester] [or] [one quarter] and who no longer meet the Eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than [[30 - 365] days] [one semester] [one quarter] under the student association's policy in effect. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the student association. Coverage under the new policy is subject to the rates and benefits selected by the student association for that Policy Year.

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

POLICY ENDORSEMENT

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

[UnitedHealthcare Network Pharmacy] Prescription Drug Benefits

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

Copayment and/or Coinsurance Amount

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

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

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

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

Supply Limits

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

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

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

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

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing [through the Internet at www.uhcsr.com] [or] by calling *Customer Service* at [the telephone number on the Insured's ID card] [1-800-767-0700].

If a Brand-name Drug Becomes Available as a Generic

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

[Ancillary Charge

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at the Insured Person's [or the Physician's] request and there is another drug that is chemically the same available at a lower tier. When the Insured chooses the higher tiered drug of the two, the Insured will pay the difference between the higher tiered drug and the lower tiered drug in addition to the Copayment and/or Coinsurance that applies to the [lower tiered drug] [higher tier drug].]

[Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products [as specified in the policy Schedule of Benefits]. If the Insured requires Specialty Prescription Drug Products, the Company may direct the Insured to a Designated Pharmacy with whom the Company has an arrangement to provide those Specialty Prescription Drug Products.

If the Insured is directed to a Designated Pharmacy and chooses not to obtain their Specialty Prescription Drug Product from a Designated 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 Pharmacy. The following supply limits apply to Specialty Prescription Drug Products.

As written by the Physician, up to a consecutive [31] [60]-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy[,] [mail-order Pharmacy] [or] [a Designated Pharmacy].]

[Designated Pharmacies

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

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

[Notification Requirements

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

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

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at [www.uhscr.com] or by calling *Customer Service* at [the telephone number on the Insured's ID card] [1-800-767-0700].

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

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

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

[Step Therapy

Certain Prescription Drug Products for which benefits are provided are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products an Insured is required to use a different Prescription Drug Product(s) first.

The Insured may determine whether a particular Prescription Drug Product is subject to step therapy requirements through the Internet at [www.uhcsr.com] or by calling *Customer Service* at [the telephone number on the Insured's ID card] [1-800-767-0700].]

[Limitation on Selection of Pharmacies

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

Coverage Policies and Guidelines

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

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

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

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

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. Please access [www.uhcsr.com] through the Internet or call *Customer Service* [at the telephone number on the Insured's ID card] [1-800-767-0700] 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 and/or Coinsurance.

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

Definitions

[Ancillary Charge means a charge, in addition to the Copayment and/or Coinsurance, that the Insured is required to pay when a covered Prescription Drug Product is dispensed at the Insured's [or the Physician's] request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Cost or MAC list price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Cost or MAC list price of the Chemically Equivalent Prescription Drug Product available on the lower tier.]

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

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

[Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products[, including, but not limited to, Specialty Prescription Drug Products]. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.]

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

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

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

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

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

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

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

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

[Maximum Allowable Cost (MAC) List means a list of Generic Prescription Drug Products that will be covered at a price level that the Company establishes. This list is subject to the Company's periodic review and modification.]

Network Pharmacy means a pharmacy that has:

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

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

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at [www.uhcsr.com] or call *Customer Service* [at the telephone number on the Insured's ID card] [1-800-767-0700].

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

[Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products through the Internet at [www.uhcsr.com] or call *Customer Service* [at the telephone number on the Insured's ID card] [1-800-767-0700].]

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

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- [[2.] Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.]

- [[3.] [Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-[2] [3] [4].] [Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.]]
- [[4.] Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.]
- [[5.] Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury[,except as required by state mandate].]
- [[6.] A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.]
- [[7.] 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.]

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

**RESOLUTION OF GRIEVANCE NOTICE
INTERNAL APPEAL PROCESS AND EXTERNAL INDEPENDENT REVIEW PROCESS
RELATED TO HEALTH CARE SERVICES**

DEFINITIONS

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

Adverse Determination means:

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

Authorized Representative means:

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

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

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

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

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

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

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

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

INTERNAL APPEAL PROCESS

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

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

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

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

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

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

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

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

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

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

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

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
 - a. the date of service;
 - b. the name health care provider; and
 - c. the claim amount;
3. A statement 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 received, 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 External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation; 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.

Expedited Internal Review (EIR) of an Adverse Determination

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

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

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

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

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

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the 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.

EXTERNAL INDEPENDENT REVIEW

An Insured Person or Authorized Representative may submit a request for an External Independent Review when the service in question:

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an External Independent Review. Except for a request for an Expedited External Review, the request for an External Review should be made in writing to the Commissioner. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

I. Standard External Review (SER) Process

1. Within 5 business days after receiving the SER request notice, the Company will complete a preliminary review to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. the Insured Person has exhausted the Company's Internal Appeal Process;
 - c. the Insured Person has provided all the information and forms necessary to process the request; and
 - d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
2. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
3. After receiving notice that a request is eligible for SER, the Commissioner shall, within 1 business day:
 - a. Assign an Independent Review Organization (IRO) from the Commissioner's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4.
 - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
 - b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
 - c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

II. Expedited External Review (EER) Process

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

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

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

2. Upon receipt of an EER request, the Commissioner shall immediately send a copy of the request to the Company.
3. Upon receipt of a request for an EER, the Company shall immediately review the request to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;
 - b. the Insured Person has exhausted the Company's Internal Appeal Process, unless the Insured Person is not required to do so as specified in sections II. 1. a. and b. shown above;
 - c. the Insured Person has provided all the information and forms necessary to process the request; and
 - d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.
4. Immediately after completion of the review, the Company shall notify the Commissioner, the Insured Person and the Authorized Representative, if applicable, whether the request is eligible for an EER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete;
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner
5. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an IRO from the Commissioner's approved list and notify the Company of the name of the assigned IRO.
 - a. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination.
 - b. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6.
 - a. If the EER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7. In no more than 72 hours after receipt of the qualifying EER request, the IRO shall:
 - a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
 - b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.
8. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

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

1. For an Adverse Determination or a Final Adverse Determination that involves denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or an Authorized Representative may submit a request for a Standard Experimental or Investigational Treatment External Review (SEIER) with the Commissioner.
2. Within 5 business days after receiving the SEIER request notice, the Company will complete a preliminary review to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;
 - b. the recommended or requested health care services or treatment:

- (i) is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. the Insured Person's treating Physician has certified that one of the following situations is applicable:
 - (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
 - (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. the Insured Person's treating Physician:
 - (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. the Insured Person has exhausted the Company's Internal Appeal Process; and
 - f. the Insured Person has provided all the information and forms necessary to process the request.
3. Within 1 business day after completion of the preliminary review, the Company shall notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for a SEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
 - b. If the request is not eligible, the Company response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
 4. After receiving notice that a request is eligible for SEIER, the Commissioner shall, within 1 business day:
 - a. Assign an IRO from the Commissioner's approved list;
 - b. Notify the Company of the name of the assigned IRO; and
 - c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 5 business days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
 5.
 - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the SEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
 6. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SEIER.
 - b. The SEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
 7. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 20 calendar days after being selected by the IRO.
 8. The IRO shall make a decision and provide oral or written notice of its decision within 20 days after receipt of the opinions from each clinical reviewer.
 9. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

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

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

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

2. Upon receipt of an EEIER request notice, the Company shall immediately complete a preliminary review to determine that:
 - a. the individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
 - b. the recommended or requested health care services or treatment:
 - (i) is a Covered Medical Expense under the Insured Person's Policy except for the Company's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person's Policy;
 - c. the Insured Person's treating Physician has certified that one of the following situations is applicable:
 - (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
 - (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
 - (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
 - d. the Insured Person's treating Physician:
 - (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician's opinion, than any available standard health care services or treatments; or
 - (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person's condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
 - e. the Insured Person has exhausted the Company's Internal Appeal Process unless the Insured person is not required to do so as specified in Section IV. 1. a. and b. above; and
 - f. the Insured Person has provided all the information and forms necessary to process the request.
3. The Company shall immediately notify the Commissioner, the Insured Person and, if applicable, the Authorized Representative in writing whether the request is complete and eligible for an EEIER.
 - a. If the request is not complete, the Company's response shall include what information or materials are needed to make the request complete; or
 - b. If the request is not eligible, the Company's response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
4. After receiving notice that a request is eligible for EEIER, the Commissioner shall immediately:
 - a. Assign an IRO from the Commissioner's approved list; and
 - b. Notify the Company of the name of the assigned IRO.

5. The Company shall provide or transmit all necessary documents and information considered in making the Adverse Determination or Final Adverse Determination. All documents shall be submitted to the IRO electronically, by telephone, via facsimile, or by any other expeditious method.
6.
 - a. If the EEIER is related to an Adverse Determination for which the Insured Person or the Authorized Representative filed the EEIER concurrently with an Expedited Internal Review (EIR) request, then the IRO will determine whether the Insured Person shall be required to complete the EIR prior to conducting the EEIER.
 - b. The IRO shall immediately notify the Insured Person and the Authorized Representative, if applicable, that the IRO will not proceed with EEIER until the Company completes the EIR and the Insured Person's grievance remains unresolved at the end of the EIR process.
7.
 - a. The Company shall, within 5 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company's failure to provide the documents and information will not delay the EEIER.
 - b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
8. Each clinical reviewer assigned by the IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
9. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
 - a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the EEIER.
 - b. The EEIER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the EEIER.
 - c. If the Company reverses its decision, the Company shall immediately provide written notification to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the EEIER.
10. Each clinical reviewer shall provide an oral or written opinion to the IRO no later than 5 calendar days after being selected by the IRO.
11. The IRO shall make a decision and provide oral or written notice of its decision within 72 hours after receipt of the opinions from each clinical reviewer.
12. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

BINDING EXTERNAL REVIEW

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

POLICY ENDORSEMENT

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

BENEFITS FOR MAMMOGRAPHY

[If elected by the Policyholder,] benefits will be paid the same as any other Sickness for Screening Mammography for the presence of occult breast cancer, which shall include payment for both the professional and technical components. When there is a claim for professional services separate from the claim for technical services, the claim for professional component will not be less than forty percent (40%) of the total fee.

Benefits will be paid according to the following guidelines:

- (1) A baseline mammogram for an Insured Person who is thirty-five (35) to forty (40) years of age;
- (2) A mammogram for an Insured Person who is forty (40) to forty-nine (49) years of age, inclusive every one (1) to two (2) years based on the recommendation of the Insured's Physician;
- (3) A mammogram each year for an Insured Person who is at least fifty (50) years of age; and
- (4) Upon recommendation of an Insured's Physician, without regard to age, where such Insured has had a prior history of breast cancer or where such Insured's mother or sister has had a history of breast cancer.

Benefits for Screening Mammograms will not reduce benefits payable for Diagnostic Mammograms when recommended by the Insured's Physician.

- (1) "**Mammography**" means radiography of the breast.
- (2) "**Screening mammography**" is a radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. The procedure entails two (2) views of each breast and includes a Physician's interpretation of the results of the procedure.
- (3) "**Diagnostic mammography**" is a problem-solving radiologic procedure of higher intensity than screening mammography provided to Insured who are suspected to have breast pathology. Patients are usually referred for analysis of palpable abnormalities or for further evaluation of mammographically detected abnormalities. All images are immediately reviewed by the Physician interpreting the study and additional views are obtained as needed. A physical examination of the breast by the interpreting Physician to correlate the radiologic findings is often performed as part of the study.

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

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

POLICY ENDORSEMENT

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

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER TREATMENT

[If elected by the Policyholder,] benefits will be paid the same as any other Sickness for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment shall include both surgical and nonsurgical procedures. Benefits shall be provided for medically necessary diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. Benefits shall be the same as that provided for any other musculoskeletal disorder in the body and shall be provided whether prescribed or administered by a Physician or dentist.

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

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

POLICY ENDORSEMENT

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

BENEFITS FOR HOSPICE CARE

[If elected by the Policyholder,] benefits will be paid the same as any other Sickness for Hospice Care for terminally ill Insureds.

Such services must be provided by a Hospital, related institution, home health agency, hospice or other licensed facility under a Hospice Care program. Such services must be a part of a Hospice Care Program for:

- (a) Inpatient care services;
- (b) Physician services; or
- (c) Home hospice care services.

Benefits are not payable under this part for expense incurred on or after an Insured's Medicare Eligibility Date.

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

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

POLICY ENDORSEMENT

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

BENEFITS FOR HEARING AIDS

[If elected by the Policyholder,]benefits will be paid for Hearing Aids or hearing instruments sold by a professional licensed by the state to dispense Hearing Aids or hearing instruments. Benefits begin on the first day of coverage and will not exceed [\$1,400] maximum per ear for each three year period.

“Hearing Aid” means an instrument or device, including repair and replacement parts, that: a) is designed and offered for the purpose of aiding Insured Persons with or compensating for impaired hearing; b) is worn in or on the body; and c) is generally not useful to an Insured Person in the absence of a hearing impairment.

Benefits shall not be subject to the Deductible and Copayments. All other Coinsurance, limitations, or any other provisions of the policy shall apply.

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.

SERFF Tracking #:

UHLC-128731917

State Tracking #:

Company Tracking #:

COL-12A-AR

State: Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI: H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name: Blanket Student Association Injury and Sickness Policy

Project Name/Number: /COL-12A-AR

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/13/2012
Comments:			
Attachment(s):	AR Certificate of Compliance.pdf Certificate of Readability - COL-12A-AR.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/13/2012
Comments:	The application(s) to be used with this filing appear under the forms tab. Please see COL-12A-AR AP1 and COL-12A-AR AP2.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/13/2012
Bypass Reason:	Summary form states to indicate which product is being amended. This is NOT an amendment to an existing filing, it is a completely new product filing.		

		Item Status:	Status Date:
Satisfied - Item:	Form Filing List	Approved-Closed	11/13/2012
Comments:			
Attachment(s):	Form Filing List.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved-Closed	11/13/2012
Comments:			
Attachment(s):	Cover Letter.pdf		

Item Status:

Status Date:

SERFF Tracking #:

UHLC-128731917

State Tracking #:

Company Tracking #:

COL-12A-AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name:

Blanket Student Association Injury and Sickness Policy

Project Name/Number:

/COL-12A-AR

Satisfied - Item:	Objection Response Ltr 10-31-12	Approved-Closed	11/13/2012
Comments:			
Attachment(s):			
Objection Response 10-31-12.pdf			

Item Status:

Status Date:

Satisfied - Item:	Objection Response Ltr 11-05-12	Approved-Closed	11/13/2012
Comments:			
Attachment(s):			
Objection Response 11-05-12.pdf			

Item Status:

Status Date:

Satisfied - Item:	Objection Response Ltr 11-06-12	Approved-Closed	11/13/2012
Comments:			
Attachment(s):			
Objection Response 11-06-12.pdf			

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: UnitedHealthcare Insurance Company

Form Number(s): COL-12A-AR, et al.

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Allen Sorbo

Name

President

Title

October 17, 2012

Date

**UNITED HEALTHCARE INSURANCE COMPANY
STATE OF ARKANSAS
CERTIFICATE OF READABILITY**

RE: Policy Form No. COL-12A-AR

1. We hereby certify that we have carefully scored the forms listed above and obtained a Flesch score of 45.1
2. The policy was printed in 10 point type, one point leaded.
3. The number of words contained in the policy text is 8154.
4. The entire form was analyzed excluding the name and address of the Insurer, the name, number and title of the form, the table of contents, captions and subscriptions, the specification page, medical terminology, and any schedules and tables.
5. To the best of our knowledge and belief, we find that the said form complies with the standards of Arkansas Code Ann. 23-80-206.

By 

Allen Sorbo
President

Date: October 17, 2012

ARKANSAS Form Filing List

Form

Description

COL-12A-AR

COL-12A-AR SOB

COL-12A-AR SOB PPO

COL-12A-AR AP1

COL-12A-AR AP2

Blanket Student Association Injury and Sickness Policy Form

Schedule of Benefits – Usual and Customary

Schedule of Benefits – PPO

Policyholder Application

Application Attachment

Policy Endorsements

COL-12A-AR END (5A)

COL-12A-AR END (5B)

COL-12A END (5C)

COL-12A END (6B)

COL-12A END (6E)

COL-12A END (7)

Excess Provision

Excess Provision

Coordination of Benefits Provision

Accidental Death and Dismemberment Benefit

[Accidental] Death Benefit

Pre-Admission Notification

COL-12A END (12)

COL-12A END (15)

COL-12A END (16)

COL-12A END (RX)

GR-12-AR

Dental Benefits

Live Organ or Bone Marrow Donor Benefits

Continuation Privilege

UHC Network Pharmacy Prescription Drug Benefits

Resolution of Grievances

Mandated Offer Endorsements

COL-12AMOE-AR END (3)

COL-12AMOE-AR END (5)

COL-12AMOE-AR END (6)

COL-12AMOE-AR END (8)

Benefits for Mammography

Benefits for Temporomandibular Joint Disorder Treatment

Benefits for Hospice Care

Benefits for Hearing Aids



StudentResources
2301 West Plano Parkway
Suite 300
Plano, TX 75075
1-888-767-0700

October 18, 2012

Honorable Jay Bradford
Commissioner of Insurance
Arkansas Department of Insurance
Life and Health Division
1200 W 3rd St.
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company

NAIC# 79413

Form No: COL-12A-AR, et al (please refer to attached list for complete form listing)

Dear Commissioner Bradford:

Enclosed for your consideration and approval is our original submission of the above referenced blanket student association injury and sickness policy. Form COL-12A-AR will be marketed to student associations in your state to insure colleges and university students who are members of the student association. This form is being filed as a result of PPACA and the final rule for student health insurance coverage, which makes a distinction between student health coverage provided to a policy issued to an institution of higher education and that issued to a student association. This plan is being filed for use with the 2012-2013 policy year.

The policy received a Flesch readability score of 45.1.

This form filing is being filed concurrently in our domiciliary state of Connecticut.

Also enclosed is the required certifications, filing forms and listing of forms for approval.

We appreciate your prompt review and approval of this form. Should you have any questions or need further information, please contact me by phone at (800) 767-0700, extension 6859, via e-mail at mwenshau@uhcsr.com, or by fax at (469) 229-5535.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mark Wenshau'.

Mark Wenshau, HIA, HIPAAA
Compliance Analyst
UnitedHealthcare **StudentResources**



StudentResources
2301 West Plano Parkway
Suite 300
Plano, TX 75075
1-888-767-0700

October 31, 2012

Rosalind Minor,
Analyst,
Arkansas Department of Insurance
Life and Health Division
1200 W 3rd St.
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company
SERFF Filing # UHLC-128731917
Form No: COL-12A-AR, et al

NAIC# 79413

Dear Ms. Minor:

We have received your objection letter dated October 24, 2012 and are responding below. Your objections and concerns are listed in bold followed by our responses.

Before approval is given to this filing, it is requested that you provide us with a few examples of the student associations. It is also requested that you certify that benefits payable In-Network and Out-of-Network comply with our Bulletin 9-85 which states in part that benefits payable will not be greater than 25%.

Our list of student associations is too large to list here, but includes:

1. American Student Dental Association (ASDA)
2. National Student Nurses Association (NSNA)
3. American Bar Association – Law Student Division (ABA)
4. American College Student Association (ACSA)
5. American Physical Therapy Association (APTA)

In addition, with this letter we certify that benefits payable In-Network and Out-of-Network do indeed comply with Arkansas Bulletin 9-85 and that the payment differential will never be greater than 25%.

We appreciate your continued review and approval of this form. Should you have any questions or need further information, please contact me by phone at (800) 767-0700, extension 6859, via e-mail at mwenshou@uhcsr.com, or by fax at (469) 229-5535.

Sincerely,

Mark Wenshou, HIA, HIPAAA
Compliance Analyst
UnitedHealthcare **StudentResources**



StudentResources
2301 West Plano Parkway
Suite 300
Plano, TX 75075
1-888-767-0700

November 5, 2012

Rosalind Minor,
Analyst,
Arkansas Department of Insurance
Life and Health Division
1200 W 3rd St.
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company
SERFF Filing # UHLC-128731917
Form No: COL-12A-AR, et al

NAIC# 79413

Dear Ms. Minor:

We have received your objection letter dated November 2, 2012 and are responding below. Your objections and concerns are listed in bold followed by our responses.

Under Part II, Entire Contract Changes, please add a statement that reads: that " all statements made by the policyholder shall, in the absence of fraud, be deemed representations and not warranties....". Please review ACA 23-86-102(1).

Our Entire Contract Changes provision states that the policy, endorsements and application constitutes the entire contract between the policyholder and the Company. We would like to point out that our application does not contain any questions that would be deemed statements made by the Policyholder that would affect a claim payment. Therefore we do not believe the statement needs to be added.

We appreciate your continued review and approval of this form. Should you have any questions or need further information, please contact me by phone at (800) 767-0700, extension 6859, via e-mail at mwenshau@uhcsr.com, or by fax at (469) 229-5535.

Sincerely,

Mark Wenshau, HIA, HIPAAA
Compliance Analyst
UnitedHealthcare **StudentResources**



StudentResources
2301 West Plano Parkway
Suite 300
Plano, TX 75075
1-888-767-0700

November 6, 2012

Rosalind Minor,
Analyst,
Arkansas Department of Insurance
Life and Health Division
1200 W 3rd St.
Little Rock, AR 72201-1904

RE: UnitedHealthcare Insurance Company
SERFF Filing # UHLC-128731917
Form No: COL-12A-AR, et al

NAIC# 79413

Dear Ms. Minor:

We have received your objection letter dated November 6, 2012 and are responding below. Your objections and concerns are listed in bold followed by our responses.

As discussed in our telephone conversation on 11/05/12, it is requested that you add, under Entire Contract Changes, the wording: “In the absence of Fraud”.

Thank you for taking the time to call me yesterday. As instructed and per ACA 23-86-102(1), I have added the required text to our Entire Contract Changes provision on page 2 of the policy.

We appreciate your continued review and approval of this form. Should you have any questions or need further information, please contact me by phone at (800) 767-0700, extension 6859, via e-mail at mwenshau@uhcsr.com, or by fax at (469) 229-5535.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mark Wenshau'.

Mark Wenshau, HIA, HIPAAA
Compliance Analyst
UnitedHealthcare **StudentResources**

SERFF Tracking #:

UHLC-128731917

State Tracking #:**Company Tracking #:**

COL-12A-AR

State:

Arkansas

Filing Company:

UnitedHealthcare Insurance Company

TOI/Sub-TOI:

H04 Health - Blanket Accident/Sickness/H04.001 Student

Product Name:

Blanket Student Association Injury and Sickness Policy

Project Name/Number:

/COL-12A-AR

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/17/2012	Replaced 11/13/2012	Form	Blanket Student Association Injury and Sickness Policy	11/06/2012	COL-12A-AR.pdf (Superseded)

UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office Address: P.O. Box 809025, Dallas, TX 75380-9025
BLANKET STUDENT ASSOCIATION ACCIDENT AND SICKNESS POLICY

POLICYHOLDER	[ANY STUDENT ASSOCIATION]	POLICY NUMBER	[12-0000]
ADDRESS	[111 ANY ST.]	Effective Date	[2012-2013] ACADEMIC YEAR
	[ANY CITY, STATE]	Termination Date	[2012-2013] ACACEMIC YEAR

PREMIUM FOR EACH INSURED PERSON

SEE APPLICATION ATTACHED

LIST OF ENDORSEMENTS ATTACHED TO AND FORMING A PART OF THIS POLICY

UNITEDHEALTHCARE INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this policy to pay the benefits provided by this policy for loss resulting from a cause covered by this policy. This policy is issued in consideration of the application and payment of the premiums. Premiums as specified above are payable for each Insured Person.

Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed



President

Countersigned by _____ Licensed Resident Agent

PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1) two years after the termination of this policy and 2) the date of final adjustment and settlement of all claims under this policy.

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**PART I
ELIGIBILITY AND TERMINATION PROVISIONS**

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. [[The Named Insured must actively attend classes for at least the first [31 [1-45]] days after the date for which coverage is purchased.] [[Home study,] [correspondence,] [and] [online] courses do not fulfill the eligibility requirements[that the Named Insured actively attend classes].] The Company maintains its right to investigate [eligibility or] student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.]

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

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

[Dependent eligibility expires concurrently with that of the Named Insured.]]

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

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

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

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

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

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

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

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

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

**PART II
GENERAL PROVISIONS**

ENTIRE CONTRACT CHANGES: This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. Coverage under the policy may not be cancelled and no refunds will be provided unless the Insured enters the armed forces. A pro-rata premium will be refunded upon request when the insured enters the armed forces. [Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment.] [The Named Insured may purchase optional coverages for himself or for himself and all Dependent family members[, unless the optional coverage is available only to the Named Insured.]]

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

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

CLAIM FORMS: [Upon receipt of a notice of claim, the Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of written notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.] [Claim forms are not required.]

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

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

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

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

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

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

In the event that the Insured recovers from the third party, reasonable cost of collection and attorney's fees thereof shall be assessed against the Company and the Insured in the proportion each benefits from the recovery. In the event more than one casualty insurer, health insurer, health maintenance organization, self-funded group, multiple-employer welfare arrangement or hospital or medical services corporation having contractual subrogation rights are entitled to the subrogation benefits, reasonable cost of collection and attorney's fees thereof shall be assessed against the insurers and the Insured in the proportion each benefits from the recovery.

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

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

PART III DEFINITIONS

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

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

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

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

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

CUSTODIAL CARE means services that are any of the following:

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

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

[**DEPENDENT** means the spouse (husband or wife) [or Domestic Partner] of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of [26 – 30] years.

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

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

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

Dependent shall also include any minor under the charge, care and control of the Named Insured that the Insured has filed a petition to adopt. Coverage shall begin:

- 1) On the date of the filing of the petition for adoption, provided the Named Insured applies within sixty (60) days after the filing of the petition for adoption; or
- 2) From the moment of birth, provided the petition for adoption and application for coverage is filed within (60) days after the birth of the minor.

Coverage shall terminate upon the dismissal or denial of a petition for adoption.]

[DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; [and] 3) is responsible with the Named Insured for each other's welfare; and 4) is the same sex as the Named Insured]. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured's will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.]

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

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

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

INJURY means bodily injury which is all of the following:

- 1) directly and independently caused by specific accidental contact with another body or object.
- 2) unrelated to any pathological, functional, or structural disorder.
- 3) a source of loss.
- 4) treated by a Physician within [30 - 365] days after the date of accident.
- 5) sustained while the Insured Person is covered under this policy.

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

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

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

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

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

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

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

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

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

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

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

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

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

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

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

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

[NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 90 days after birth. Coverage for such a child will be for Injury or Sickness, including congenital defects, premature birth, and tests for hypothyroidism, phenylketonuria and galactosemia, and, in the case of non-Caucasian Newborn Infants, tests for sickle-cell anemia, as well as any testing of Newborn Infants hereafter mandated by law and shall also include coverage to pay for routine nursery care and pediatric charges for a well Newborn Infant for up to five (5) full days in a hospital nursery, or until the mother is discharged from the hospital following the birth of the child, whichever is less.

[The Insured will have the right to continue such coverage for the child beyond the first 90 days. To continue the coverage the Insured must, within the 90 days after the child's birth: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 90 days after the child's birth.]]

[OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

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

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

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

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

[PRE-EXISTING CONDITION means[: 1) the existence of symptoms [which would cause an ordinarily prudent person to seek diagnosis, care or treatment] within the [3 - 12] months immediately prior to the Insured's Effective Date under the policy; or, 2)] any condition which [originates,] is diagnosed, treated or recommended for treatment within the [3 - 12] months immediately prior to the Insured's Effective Date under the policy.]

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

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

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

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

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

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

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

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

**[PART IV
[COVERED LOSS - TIME LIMITS**

Covered Medical Expenses will be paid under the Schedule of Benefits for loss[:]

- [1)] Due to Injury to an Insured Person provided that treatment by a Physician: a) begins within [30 – 365] days after the date of Injury; and, b) is received within [12 – 24] months after date of Injury[; or,
- 2) Due to Sickness of an Insured Person provided Covered Medical Expenses are incurred within [12 – 24] months after the date of first treatment for such Sickness].]

[EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury [or Sickness] for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury [or Sickness] will continue to be paid as long as the condition continues but not to exceed [[30 – 365] days] [[12 – 24] months] after the Termination Date.

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

[EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured incurs medical expenses within [30 - 365] days of 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:

- 1) When not Hospital Confined on the Termination Date, not to exceed [30 – 365] days after the Termination Date; or
- 2) When Hospital Confined on the Termination Date, not to exceed [[30 – 365] days] [[12 – 24] months] after the Termination Date.

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

If the Insured is also an Insured under the succeeding policy issued to the Policyholder; this "Extension of Benefits" provision will not apply.]]

INSERT
SCHEDULE OF BENEFITS
HERE

[PART [VI]
PREFERRED PROVIDER INFORMATION

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

[List Preferred Providers in School Area here]]

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling [the Company at [1-800-767-0700]] and/or by asking the provider when making an appointment for services.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

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

[**“Network Area”** means the [10 – 50] mile radius around the local school campus the Named Insured is attending.]

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at [[50 – 100]% [the Coinsurance percentages specified in the Schedule of Benefits], up to any limits specified in the Schedule of Benefits. [Preferred Hospitals include [UnitedHealthcare Options PPO] United Behavioral Health (UBH) facilities.] Call [(800) 767-0700] for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

[Professional & Other Expenses

Benefits for Covered Medical Expenses provided by [name of network or Physician groups] will be paid at [[50 – 100]% of Preferred Allowance] [the Coinsurance percentages specified in the Schedule of Benefits]-or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.]

[SPECIAL PROVIDER ARRANGEMENTS

[Affiliated Physicians, Inc. and Doctors Walk-In Clinics] [have] agreed to accept special reduced reimbursement rates for treatment rendered to Insureds. Eligible [Physician] services provided by [Affiliated Physicians, Inc. and Doctors Walk-In Clinics] will be paid at [[50 – 100]% of these negotiated 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.]]

PART [VII]
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any Coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

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

1. **Room and Board Expense:** 1) daily semi-private room rate when confined as an Inpatient; and 2) general nursing care provided and charged by the Hospital.
2. **[Intensive Care:** If provided in the Schedule of Benefits.]
3. **[Hospital Miscellaneous Expenses:** 1) when confined as an Inpatient; or 2) as a precondition for being confined as an Inpatient. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take home drugs) or medicines; [therapeutic services;] and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.]
4. **Routine Newborn Care:** 1) while Hospital Confined; and 2) routine nursery care provided immediately after birth. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.
5. **[Physiotherapy (Inpatient):** See Schedule of Benefits.]
6. **Surgery:** Physician's fees for Inpatient surgery. [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]
7. **[Assistant Surgeon Fees:** in connection with Inpatient surgery, if provided in the Schedule of Benefits.]
8. **Anesthetist Services:** professional services administered in connection with Inpatient surgery.
9. **Registered Nurse's Services:** [1] private duty nursing care only; [2] while an Inpatient; [3] ordered by a licensed Physician; and [4] a Medical Necessity. General nursing care provided by the Hospital[, Skilled Nursing Facility] [or] [Inpatient Rehabilitation Facility] is not covered under this benefit.
10. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. [Benefits are limited to one visit per day.] [Benefits do not apply when related to surgery.] [Covered Medical Expenses will be paid under the Inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.]
11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. [This benefit is payable within [3 - 14] working days prior to admission.]
12. **Surgery (Outpatient):** Physician's fees for outpatient surgery. [If two or more procedures are performed through the same incision or in immediate succession at the same operative session, The maximum amount paid will not exceed [50 – 100]% of the second procedure and [25 – 100]% of all subsequent procedures.]

13. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery[; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic]. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
14. **[Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.]
15. **[Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.]
16. **Physician's Visits (Outpatient):** [benefits are limited to one visit per day.] [Benefits do not apply when related to [surgery][or] [Physiotherapy].] [Benefits include [surgery,] [X-rays,] [laboratory procedures] [and] [tests and procedures] when performed in the Physician's Office.] [Covered Medical Expenses will be paid under the outpatient benefit or under the Inpatient benefit for Physician's Visits, but not both on the same day.] Physician's Visits for preventive care are provided as specified under Preventive Care Services.
17. **[Physiotherapy (Outpatient):** [benefits are limited to one visit per day]. Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) See also Benefits for the Treatment of Speech and Hearing Disorders. [Review of Medical Necessity will be performed after [12 - 24] visits per [Injury] [or] [Sickness].]
18. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for [the attending Physician's charges,] [X-rays,] [laboratory procedures,] [tests and procedures,] [injections,] the facility charge for use of the emergency room and supplies. [Treatment must be rendered within [72][48-120] hours from time of Injury or first onset of Sickness.]
19. **Diagnostic X-ray Services (Outpatient):** [Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.] X-ray services for preventive care are provided as specified under Preventive Care Services.
20. **[Radiation Therapy (Outpatient):** See Schedule of Benefits.]
21. **Laboratory Procedures (Outpatient):** [Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.] Laboratory procedures for preventive care are provided as specified under Preventive Care Services.
22. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures. The following therapies will be paid under the Tests and Procedures (Outpatient) benefit: inhalation therapy; infusion therapy; pulmonary therapy; and respiratory therapy. Tests and Procedures for preventive care are provided as specified under Preventive Care Services.
23. **[Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.]
24. **[Chemotherapy (Outpatient):** See Schedule of Benefits.]
25. **[Prescription Drugs (Outpatient):** See Schedule of Benefits.]
26. **[Ambulance Services:** See Schedule of Benefits.]
27. **[Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. See also Benefits for Orthotic and Prosthetic Devices and Services. [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.]
28. **[Consultant Physician Fees:** [when requested and approved by the attending Physician.]]

29. **[Dental Treatment:** [1)] performed by a Physician[; and, 2) made necessary by Injury to Sound, Natural Teeth]. [Breaking a tooth while eating is not covered.] [Routine dental care and treatment to the gums are not covered.]]
30. **Mental Illness Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; and 2) on an outpatient basis including intensive outpatient treatment. [Benefits are limited to one visit per day.]
31. **Substance Use Disorder Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; 2) on an outpatient basis including intensive outpatient treatment. [Benefits are limited to one visit per day.]
32. **Maternity:** Same as any other Sickness. Benefits will be paid for an inpatient stay of at least: 1) 48 hours following a vaginal delivery; or 2) 96 hours following a cesarean section delivery. If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames.
33. **Complications of Pregnancy:** Same as any other Sickness.
34. **Preventive Care Services:** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
35. **Reconstructive Breast Surgery Following Mastectomy:** same as any other Sickness and in connection with a covered mastectomy. See Benefits for Mastectomy and Reconstructive Breast Surgery.
36. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.
37. **[High Cost Procedures:** any outpatient procedure costing over \$[200 – 1,000]. High Cost Procedures includes: 1) C.A.T. Scan; 2) Magnetic Resonance Imaging; and 3) Laser treatment, which must be provided on an outpatient basis.]
38. **[Home Health Care:** services received from a licensed home health agency that are: 1) ordered by a Physician; 2) provided or supervised by a Registered Nurse in the Insured Person's home; and 3) pursuant to a home health plan. Benefits will be paid only when provided on a part-time, intermittent schedule and when skilled care is required. One visit equals up to four hours of skilled care services.]
39. **[Hospice Care:** when recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. Hospice care includes physical, psychological, social, and spiritual care for the terminally ill Insured and short-term grief counseling for immediate family members while the Insured is receiving hospice care. All hospice care must be received from a licensed hospice agency.]
40. **[Inpatient Rehabilitation Facility:** services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.]
41. **[Skilled Nursing Facility:** services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered: 1) in lieu of Hospital Confinement as a full-time inpatient; or 2) within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.]
42. **[Urgent Care Center:** benefits are limited to the[1)] facility or clinic fee billed by the Urgent Care Center[; and 2) the [attending Physician's charges,] [X-rays,] [laboratory procedures,] [tests and procedures,] [and] [injections]]. [All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]]

43. **[Hospital Outpatient Facility or Clinic:** benefits are limited to[: 1] the facility or clinic fee billed by the Hospital[; and 2) the attending Physician's charges,] [X-rays,] [laboratory procedures,] [tests and procedures,] [and] [injections]]. [All other services rendered during the visit will be paid as specified in the Schedule of Benefits.]]
44. **[Approved Clinical Trials:** Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include: 1) the experimental or investigational item, device or service, itself; 2) 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; or 3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

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

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

45. **[[Optional] Repatriation [(International) Students Only]:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. [This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under this policy.] [This optional benefit is subject to payment of the additional premium as specified on the application.]]
46. **[[Optional] Medical Evacuation [(International) Students Only]:** 1) when Hospital Confined for at least [three - five] consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. [This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under this policy.] [This optional benefit is subject to payment of the additional premium as specified on the application.]]
47. **[Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.]

**PART [VIII]
MANDATED BENEFITS**

BENEFITS FOR DRUGS FOR TREATMENT OF CANCER

If benefits are provided under the policy for Prescription Drugs, benefits will be paid the same as any other Sickness for any drug approved by the United States Food and Drug Administration (F.D.A.) for use in the treatment of cancer subject to the following criteria. Benefits may not be limited or excluded on the basis that the drug has not been approved by the United States FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided that the drug has been recognized as safe and effective treatment for that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more such compendia:

1. The American Hospital Formulary Service Drug Information;
2. The National Comprehensive Cancer Network Drugs and Biologics Compendium;
3. The Elsevier Gold Standard's Clinical Pharmacology;

or the drug has been recognized as safe and effective treatment for that specific type of cancer in two articles from major peer-review professional medical journals that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from a major peer-reviewed professional medical journal, or other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the Commissioner.

Coverage of such drugs includes all services that are a Medical Necessity associated with the administration of the drug, provided such services are covered by the policy.

This provision shall not be construed to do any of the following:

1. Require coverage for any drug if the United States FDA has determined its use to be contraindicated for the treatment of the specific type of cancer for which the drug has been prescribed;
2. Require coverage for any experimental or investigational drug as defined by the policy;
3. Require coverage for any experimental or investigational dosage or application of a drug as defined by the policy;
4. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States FDA; or
5. Create, impair, alter, limit, modify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

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

BENEFITS FOR DIABETES

Benefits will be paid the same as any other Sickness for the treatment of diabetes mellitus, including but not limited to Type I, Type II, and gestational diabetes, for medically appropriate and necessary equipment and supplies, including podiatric appliances when prescribed by a Physician. Benefits will include training programs for diabetes self-management training and educational services used to treat diabetes, when determined by the Insured's treating Physician to be medically necessary and when provided by an appropriately licensed health care professional,. Diabetes self-management training, educational services and nutrition counseling must be provided under the direct supervision of a Physician.

"Diabetes self-management training" means instruction in an inpatient or outpatient setting. This includes medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

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

BENEFITS FOR MASTECTOMY AND RECONSTRUCTIVE BREAST SURGERY

Benefits will be paid the same as any other Sickness for mastectomy and reconstructive breast surgery following a mastectomy on one or both breasts to produce a symmetrical appearance including coverage of prostheses and physical complications of mastectomy, including lymphedemas.

Mastectomy benefits shall provide for medical and surgical benefits for any hospital stay in connection with a mastectomy for not less than forty-eight hours unless the decision to discharge the patient before the expiration of the minimum length of stay is made by an attending 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 IN VITRO FERTILIZATION

Benefits will be paid the same as any other Sickness for in vitro fertilization procedures performed at medical facilities licensed or certified by the Arkansas Department of Health as an in vitro fertilization clinic. If no such facility is licensed or certified in this State or no such licensing program is operational, then coverage shall be extended for any procedures performed at a facility that conforms to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

Benefits will be paid for in vitro fertilization services to the same extent as the benefits provided for other pregnancy-related procedures not to exceed a \$15,000 Maximum Lifetime Benefit provided that:

1. The patient is the Named Insured or the spouse of the Named Insured and a covered Dependent under this policy;
2. The patient's oocytes are fertilized with the sperm of the patient's spouse;
3. The patient and the patient's spouse have a history of unexplained infertility of at least (2) two years duration; or
4. The infertility is associated with one or more of the following medical conditions:
 - a. Endometriosis;
 - b. Exposure in utero to Diethylstilbestrol, commonly known as DES; or
 - c. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy);
5. The patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatments for which coverage is available under the policy.

Cryopreservation, the procedure whereby embryos are frozen for later implantation, shall be included as an in vitro fertilization procedure.

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

[BENEFITS FOR CHILDREN'S PREVENTIVE HEALTH CARE SERVICES

Benefits will be provided for Periodic Preventive Care Visits for covered Dependent children from the moment of birth through the age of eighteen (18) as specified below.

Benefits for Children's Preventive Health Care Services will include twenty (20) visits at approximately the following age intervals: birth, two (2) weeks, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, two (2) years, three (3) years, four (4) years, five (5) years, six (6) years, eight (8) years, ten (10) years, twelve (12) years, fourteen (14) years, sixteen (16) years, and eighteen (18) years. Benefits will be provided only to the extent that these services are provided by or under the supervision of a single Physician during the course of one (1) visit.

Benefits will be reimbursed at levels established by the Arkansas Insurance Commissioner.

"Children's preventive health care services" means Physician-delivered or Physician-supervised services for covered Dependents from birth through age eighteen (18) for Periodic Preventive Care Visits including medical history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

"Periodic preventive care visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

Benefits for the recommended immunization services will be exempt from any copayment, coinsurance, Deductible or dollar limitation provisions in the policy. All other Children's Preventive Health Care Services will be subject to all Copayment, Coinsurance, and Deductible or dollar limitation provisions in the policy.]

BENEFITS FOR PHENYLKETONURIA TREATMENT

Benefits will be paid the same as any other Sickness for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a Physician for the therapeutic treatment of phenylketonuria or other inherited metabolic disease.

Benefits will be payable after the cost of the Medical Food or low protein modified food products for an individual or a family with a Dependent child or children exceeds the two thousand four hundred dollars (\$2,400) per year per child income tax credit allowed under Arkansas Code, s 23-79-702.

"Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry; (4) "Low protein modified food product" means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

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

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

BENEFITS FOR TREATMENT OF SPEECH AND HEARING DISORDERS

Benefits will be paid the same as any other Sickness for the necessary care and treatment of Loss or Impairment of Speech or hearing subject to all terms and conditions of the policy.

The phrase "loss or impairment of speech or hearing" shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology, and which fall within the scope of his or her area of certification.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a Hospital or ambulatory surgical facility, if the Physician treating the patient certifies that, because of the Insured's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the Insured is:

1. A child under seven years of age who is determined by two dentists licensed under the Arkansas Dental Practice Act to require, without delay, necessary dental treatment in a Hospital or ambulatory surgical center for a significantly complex dental condition;
2. A person with a diagnosed serious mental or physical condition; or
3. A person with a significant behavioral problem as determined by the covered person's physician as licensed under the Arkansas Medical Practices Act.

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

BENEFITS FOR PROSTATE CANCER SCREENING

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening performed by a qualified medical professional.

Benefits include at least one screening per policy year for any male Insured Person forty (40) years of age or older in accordance with the National Comprehensive Cancer Network guidelines.

If a Physician recommends that an Insured Person undergo a Prostate Specific Antigen (PSA) blood test, benefits may not be denied on the ground that the Insured Person has already had a digital rectal examination and the examination was negative.

This benefit is not subject to the policy Deductible and will not reduce or limit any other diagnostic benefits otherwise payable under this policy, This benefit shall be subject to all other Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR ORTHOTIC AND PROSTHETIC DEVICES AND SERVICES

Benefits will be paid for Orthotic and Prosthetic Devices and Services when such devices and services are: (1) prescribed by a licensed doctor of medicine, doctor of osteopathy, doctor of podiatric medicine; and (2) provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, an orthotist, or a prosthetist licensed by the State of Arkansas.

Benefits include replacement of an Orthotic or Prosthetic device and related services, but not more frequently than one (1) time every three (3) years, unless medically necessary or necessitated by anatomical change or normal use.

"Orthotic device" means an external device that is: a.) Intended to restore physiological function or cosmesis to a patient; and b) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

"Orthotic device" does not include a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device that: a) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and b) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body;

"Orthotic service" means the evaluation and treatment of a condition that requires the use of an orthotic device;

"Prosthetic device" means an external device that is: a) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and b) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

"Prosthetic device" does not include an artificial eye, an artificial ear, a dental appliance, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body;

"Prosthetic service" means the evaluation and treatment of a condition that requires the use of a prosthetic device;

The benefit amount shall be no less than [eighty] percent [(80%)] of the Medicare allowable amount.

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

[BENEFITS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Benefits will be paid the same as any other Sickness for the Treatment of Autism Spectrum Disorder.

Autism Spectrum Disorder means: "Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders", including:

- (A) Autistic disorder;
- (B) Asperger's disorder; and
- (C) Pervasive developmental disorder not otherwise specified;

Treatment includes:

- (A) The following care prescribed, provided, or ordered for a specific individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary and evidence-based including without limitation:
 - (i) Applied behavior analysis when provided by or supervised by a Board Certified Behavior Analyst;
 - (ii) Pharmacy care;
 - (iii) Psychiatric care;
 - (iv) Psychological care;
 - (v) Therapeutic care; and
 - (vi) Equipment determined necessary to provide evidence-based treatment; and
- (B) Any care for an individual with autism spectrum disorder that is determined by a licensed physician to be:
 - (i) Medically necessary; and
 - (ii) Evidence-based.

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

[BENEFITS FOR GASTRIC PACEMAKER

Benefits will be paid the same as any other Sickness for a Gastric Pacemaker and shall be based on Medical Necessity.

Gastric Pacemaker means a medical device that:

- (A) Uses an external programmer and implanted electrical leads to the stomach; and
- (B) Transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat Gastroparesis.

“Gastroparesis” means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

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

PART [IX]
EXCLUSIONS AND LIMITATIONS

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

1. [Acne[, except as specifically provided in the policy];]
2. [Acupuncture[, except as specifically provided in the policy];]
3. [Allergy including allergy testing[, except as specifically provided in the policy];]
4. [[Addiction, such as:] [nicotine addiction, except as specifically provided in the policy;] [and] [caffeine addiction;] [non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious;] [codependency;]]
5. [Assistant Surgeon Fees;]
6. [[hyperkinetic syndromes,] [milieu therapy,] [learning disabilities,] [behavioral problems,] [[parent-child problems,] [attention deficit disorder,] [conceptual handicap,] [developmental delay or disorder or mental retardation,][except as specifically provided in the policy];]
7. [Biofeedback[, except as specifically provided in the policy];]
8. [Durable Medical Equipment;]
9. [Chemotherapy;] [Radiation Therapy;] [Injections;]
10. [Chronic pain disorders;]
11. [Circumcision;]
12. [Congenital conditions[, except as specifically provided for Newborn or adopted Infants;]]
13. [Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy [or for [newborn] [or] [adopted] children;] [except as specifically provided in the policy;]] [removal of [warts,] [non-malignant] [moles] [and] [lesions;] [except as specifically provided in the policy;]]
14. [Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, [college infirmaries] or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;]
15. [Dental treatment[, except [for accidental Injury to [Sound,] Natural Teeth] [as specifically provided in the Schedule of Benefits];]
16. [Elective Surgery or Elective Treatment;]
17. [Elective abortion;]
18. [[Eye examinations,] [eye refractions,] [eyeglasses,] [contact lenses,] [prescriptions or fitting of eyeglasses or contact lenses,] [vision correction surgery,] [or] [other treatment for visual defects and problems]; except when due to a covered Injury or disease process[or except as specifically provided in the policy];]
19. [[Flat foot conditions;] [supportive devices for the foot;] [subluxations of the foot;] [fallen arches;] [weak feet;] [chronic foot strain;] [symptomatic complaints of the feet;] [and] [routine foot care including the care, cutting and removal of [corns,] [calluses,] [toenails,] [and] [bunions (except capsular or bone surgery)];] [except as specifically provided in the policy;]]
20. [Health spa or similar facilities; strengthening programs;]

21. [[Hearing examinations;]; [hearing aids;] [or] [cochlear implants;] [except as specifically provided in the Benefits for Hearing Aids, if elected by the Policyholder;] [or] [except as specifically provided in the policy;] [or] other treatment for hearing defects and problems, except as a result of an infection or trauma, except as specifically provided in the Benefits for the Treatment of Speech and Hearing Disorders. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;]
22. [Hirsutism;] [alopecia;]
23. [Home health care;]
24. [Hospice care;]
25. [Hospital outpatient facility or clinic fee;]
26. [Hypnosis;]
27. [Immunizations, except as specifically provided in the policy;] [preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;]
28. [Injury caused by, contributed to, or resulting from the [addiction to or] use of [alcohol,] [intoxicants,] [hallucinogenics,] [illegal drugs][, or] any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;]
29. [Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;]
30. [Injury or Sickness outside the United States and its possessions[, Canada] [or] [Mexico][, except [for a Medical Emergency] when traveling for [academic study abroad programs] [business] [or] [pleasure];]
31. [Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance [in excess of \$[500 – 20,000]];]
32. [Injury sustained while (a) participating in any [interscholastic,] [high school,] [intramural,] [club,] [or] [intercollegiate,] [or professional] sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;]
33. [Injury sustained while (a) participating in any contest or competition of [intramural football, etc.] [or] [intercollegiate football, etc.]; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;]
34. [Investigational services;]
35. [Lipectomy;]
36. [[Marital] [or] [family] counseling;]
37. [Mental Illness;] [Substance Use Disorders;] [Methadone maintenance treatment for Substance Use Disorders;]
38. [Motor vehicle Injury;]
39. [Organ transplants[, including organ donation];]
40. [[Outpatient] Physiotherapy[; except for a condition that required surgery or Hospital Confinement[: 1) within the [30 - 90] days immediately preceding such Physiotherapy; or 2) within the [30 - 90] days immediately following the attending Physician's release for rehabilitation];] [or when referred by the Student Health Center;]]
41. [Participation in a riot or civil disorder; commission of or attempt to commit a felony; [or fighting;]]

42. [Pre-existing Conditions [in excess of \$[500 – 20,000]][, except for individuals who have been continuously insured under the student association’s [student insurance] policy for at least [12] consecutive months]. [The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy[provided the coverage was continuous to a date within [30 – 120] days prior to the Insured’s effective date under this policy].] This exclusion will not be applied to an Insured Person who is under age 19;]
43. [Prescription Drugs dispensed or purchased while not Hospital Confined[; except when dispensed at the Student Health Center];]
44. [Prescription Drugs, services or supplies as follows[, except as specifically provided in the policy]:
- a) [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;]
 - b) [Birth control and/or contraceptives, oral or other, whether medication or device[, regardless of intended use;] except as specifically provided in Preventive Care Services[or except as specifically provided in the policy;]]
 - c) [Immunization agents, except as specifically provided in the policy,] [biological sera,] [blood or blood products administered on an outpatient basis];
 - d) [Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs;]
 - e) [Products used for cosmetic purposes;]
 - f) [Drugs used to treat or cure baldness;][anabolic steroids used for body building;]
 - g) [Anorectics - drugs used for the purpose of weight control;]
 - h) [Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;]
 - i) [Growth hormones;]
 - j) [Drugs used for tobacco cessation, except as specifically provided in the policy]; [or]
 - k) [Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.]]
45. [Reproductive/Infertility services including but not limited to: [family planning;] [fertility tests;] [infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception;] [premarital examinations;] [impotence, organic or otherwise;] [female sterilization procedures, except as specifically provided in the policy;] [vasectomy;] [sexual reassignment surgery;] [reversal of sterilization procedures;] [except as specifically provided in the policy;]]
46. [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];]
47. [Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;]
48. [[Preventive care services;] [routine physical examinations and routine testing;] [preventive testing or treatment;] [screening exams or testing in the absence of Injury or Sickness;] except as specifically provided in the policy;]
49. [Services provided [normally without charge] by the Health Service of a college or university;] [or] [services covered or provided by a student health fee;]
50. [[Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia;] [temporomandibular joint dysfunction;] [deviated nasal septum, including submucous resection and/or other surgical correction thereof;] [nasal and sinus surgery, except for treatment of a covered Injury[or treatment of chronic purulent sinusitis];] [except as specifically provided in the policy;]]
51. [[Skydiving,] [parachuting,] [hang gliding,] [glider flying,] [parasailing,] [sail planing,] [bungee jumping,] [or] flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline; or chartered aircraft only while participating in a school sponsored [intercollegiate sport][activity]];]
52. [Sleep disorders[,except as specifically provided in the policy];]
53. [Speech therapy, except as specifically provided in the Benefits for the Treatment of Speech and Hearing Disorders;] [naturopathic services;]

54. [[Suicide or attempted suicide while sane or insane [(including drug overdose)];] [or] [intentionally self-inflicted Injury];]
55. [Supplies, except as specifically provided in the policy;]
56. [Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, [or gynecomastia;] except as specifically provided in the policy;]
57. [Travel in or upon, sitting in or upon, alighting to or from, or working on or around any [motorcycle [or]] [recreational vehicle including but not limiting to: [two- or three-wheeled] motor vehicle;] [four-wheeled all terrain vehicle (ATV);] [jet ski;] [ski cycle;] [or] [snowmobile;]]]
58. [[Skiing;] [snowboarding;] [scuba diving;] [surfing;] [roller skating;] [skateboarding;] [or] [riding in a rodeo;]]]
59. [Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;]
60. [War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);] and
61. [Weight management, weight reduction, [nutrition programs,] [treatment for obesity,] [(except) [surgery for] morbid obesity)], surgery for removal of excess skin or fat, [and] [treatment of eating disorders such as bulimia and anorexia][, except as specifically provided in the policy]. [Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.]]]