UNITEDHEALTHCARE INSURANCE COMPANY

BLANKET STUDENT HEALTH INSURANCE PLAN

CERTIFICATE OF COVERAGE

Designed Especially for the Domestic Students of

THE OHIO STATE UNIVERSITY

2023-2024

This Certificate of Coverage is Part of Policy # 2023-1098-1

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

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

NOTICE: IF THE INSURED PERSON IS COVERED BY MORE THAN ONE HEALTH CARE PLAN, THE INSURED MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE THE INSURED PERSON TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. THE INSURED PERSON SHOULD READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS PROVISION, AND COMPARE THEM TO THE RULES OF ANY OTHER PLAN UNDER WHICH THE INSURED IS COVERED.

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

NOTICE: This Certificate is not part of a Medicare supplement policy. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" which is available from the Company.

This Certificate complies with Federal Mental Health Parity and Addiction equity requirements.

UnitedHealthcare®

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Introduction

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

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

Please feel free to call the Customer Service Department with any questions about the plan. The telephone number is 1-844-206-0374. The Insured can also write to the Company at:

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

Section 1: Who Is Covered

The Master Policy covers students and their eligible Dependents, when the plan includes Dependent coverage, who have met the Policy's eligibility requirements (as shown below) and who:

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

All registered Domestic Students enrolled in a degree program and enrolled in at least six (6) credit hours for undergraduates, at least four (4) credit hours for graduate and professional students and at least three (3) credit hours for post-candidacy doctoral students are automatically enrolled in this insurance plan at registration, unless proof of comparable coverage is furnished by the published deadline of their first term of enrollment.

Coverage availability is guaranteed for all individuals who meet the eligibility requirements.

Students who do not meet the minimum credit hour requirements are not eligible to purchase the Student Health Insurance.

Students meeting the eligibility requirements are automatically enrolled in the Student Health Insurance Plan each year.

Exceptions apply to enrolled students taking one of the approved exception course numbers representing co-ops, internship, study abroad, and thesis or dissertation research. These students will be automatically charged and the health insurance premium will be included in their fees regardless of credit hours unless the student waives coverage.

The following courses are excluded from being applied towards the minimum credit hour requirement:

- Courses taken in a Non-degree status. The following programs or plans are considered non-degree:
  - Graduate Non-degree
  - Graduate Visitor
  - Undergraduate Non-degree
  - Undergraduate Visitor
  - Undergraduate Academy
  - Law Non-degree
  - Law Casual
- Students may petition for an exception if the non-degree course is graduate level, and the student has a current academic year application on file with the Graduate School.
- Courses designated as Continuing Education
- Courses taken as Audit
- Online degree plans/programs in the absence of campus based in-person courses and/or fees.

- Distance learning courses (as denoted by "mode of instruction") in absence of eligible on campus courses. Students taking all distance learning courses in the absence of eligible on campus courses may not automatically be enrolled in coverage, but may petition to enroll.

Eligible students who do not wish to enroll must waive coverage by providing proof of adequate insurance coverage by the published deadline of their first term of enrollment. This process must be completed online at www.buckeyelink.osu.edu.

Coverage for Early Arrival

Students enrolling at The Ohio State University for the first time are eligible to purchase coverage for early arrival in order to have coverage in advance of the effective date of the new term of enrollment.

Early arrival coverage provides up to four weeks of extended coverage. A pro-rated, weekly premium must be paid to the Office of The University Bursar for this coverage in addition to the standard rate for the upcoming enrolled term.

Refund Policy

Coverage will be terminated and any premium will be refunded on the student's account up through the second Friday of the school term if the student drops below eligible credit hours or withdraws from classes. For students withdrawing from the University after the second Friday of the school term, health insurance premiums will not be refunded. Exception: A covered person entering the armed forces of any country will not be covered under the policy as of the date of such entry. In this case, a pro-rata refund will be made for any such person and any covered dependents upon written request received by The Ohio State University within 90 days of withdrawal from school. There is no pro-rata or reduced premium payment for late enrollees. Refunds of premiums are allowed only upon entry into the armed forces or if eligibility requirements are not met, including but not limited to dismissal from the university.

Dependent Coverage

If the plan includes Dependent coverage, then eligible students who do enroll may also insure their Dependents.

When the policy includes Dependent coverage, eligible Dependents include:

1. The Insured Person's legal spouse.
2. The Insured Person's Domestic Partner, if Domestic Partner is included as a "Class of Person to be Insured" as specified in the Policyholder Application.
3. Dependent children up to age 26.
4. Disabled children beyond age 26 if the child is:
   (a) Incapable of self-sustaining employment by reason of intellectual disability or physical handicap.
   (b) Chiefly dependent upon the Insured Person for support and maintenance.
5. Children for whom the parent is required by court or administrative order to provide coverage.

The student (Named Insured, as defined in this Certificate) must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online degree programs with no campus-based fee or course do not fulfill the eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever the Company discovers that the Policy eligibility requirements have not been met, its only obligation is refund of premium.

When the Policy includes Dependent coverage, the eligibility date for Dependents of the Named Insured shall be determined in accordance with the following:

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

Dependent eligibility expires concurrently with that of the Named Insured.

Coverage availability is guaranteed for all individuals who meet the eligibility requirements specified above.

Special Enrollment Period

Eligible students may enroll themselves and their eligible Dependents, if the plan includes Dependent coverage, during a special enrollment period. A special enrollment period is not available to an eligible student or eligible Dependent if coverage under the prior plan ended for cause or because premiums were not paid on a timely basis.

A special enrollment period applies to an eligible student and any eligible Dependent when one of the following events occurs:

1. Birth.
2. Legal adoption.
3. Placement for adoption.
4. Marriage.

A special enrollment period also applies for an eligible student and/or eligible Dependent who did not enroll during the initial enrollment period if any of the following are true:

1. The eligible student previously declined coverage under the Policy, but the eligible student and/or eligible Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the completed enrollment form and any required premium is received by the Company within 60 days of the date of determination of subsidy eligibility.
2. The eligible student and/or eligible Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the initial enrollment period and coverage under the prior plan ended because of any of the following:
   - Loss of eligibility (including legal separation, divorce or death).
   - The employer stopped paying the contributions. This is true even if the eligible student and/or eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
   - In the case of COBRA continuation coverage, the coverage ended.
   - The eligible student and/or eligible Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
   - The plan no longer offers benefits to a class of individuals that includes the eligible student and/or Dependent.
   - The eligible student and/or eligible Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if the completed enrollment form and any required premium is received by the Company within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The completed enrollment form and any required Premium must be received by the Company within 31 days of the event unless otherwise noted above.

For an eligible student and/or eligible Dependent who did not enroll during the initial enrollment period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the completed enrollment form and any required premium is received by the Company within 31 days of the date coverage under the prior plan ended.

Medicare Eligibility

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

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

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

Section 2: Effective and Termination Dates

The Master Policy becomes effective at 12:01 a.m., July 18, 2023. The Insured Person's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later.

The Master Policy terminates at 11:59 p.m., August 12, 2024. The Insured Person's coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. When the Policy includes Dependent coverage, the coverage provided with respect to any Dependent shall not be effective prior to that of the Insured student or extend beyond that of the Insured student.

The Policy provides One Year Term coverage. Coverage renewal is guaranteed for the Named Insured and eligible Dependents, when the plan includes Dependent coverage, as long as the Policy remains in force and the Named Insured continues to meet the eligibility requirements of the Policy. Dependent coverage ceases when the individual no longer meets the definition of Dependent in the Policy.

Section 3: Coverage Status and Qualifying Events

There are four types of coverage status available:

1. Student Only
2. Student and Spouse/Domestic Partner
3. Student and Child(ren)
4. Student and Family: Spouse/Domestic Partner, and Child(ren).

The default coverage status is for single, Student Only. Students who want to change their coverage status must change coverage online through http://www.buckeyelink.osu.edu by the deadline for the first term of enrollment each policy year.

Students are required to remain in the same coverage status initially selected upon enrollment for each term Student Health Insurance is purchased between Autumn 2023 and Summer 2024, unless the student experiences a qualifying event, as defined below.

Qualifying Event
The Student must meet minimum eligibility requirements for the term of the qualifying event. A qualifying event is defined as an event that could result in a change of Coverage Status and includes: 1) marriage, divorce or initially meeting requirements of domestic partnership, 2) child birth or adoption, 3) death, 4) dependent reaching the age limit of another health insurance plan, 5) first time arrival of dependent to the United States from a foreign homeland, 6) gain of coverage as result of the student becoming employed, 7) a change in the student, parent, or spouse's employment resulting in eligibility for benefits or the involuntary loss of coverage, and 8) attainment of minimum eligibility requirements after the second Friday of the term.

Note: Open enrollment is not considered to be a qualifying event. Eligibility for or loss of university subsidy, government subsidy programs, or other changes in financial circumstance are not qualifying events. Contact Buckeye Link for payment options at (614) 292-0300.

If a student experiences a qualifying event, the student must complete and submit a Coverage Status Change Form along with supporting documentation to the Student Health Insurance office within 31 days of the qualifying event. If a student experiences a qualifying event during a term that the student is not enrolled, a Coverage Status Change Form along with supporting documentation should still be sent to the Student Health Insurance office within 31 days of the qualifying event, but the effective date of the requested change will be the first day of the term in which the student returns to The Ohio State University.

If the Coverage Status Change Form representing a request to add coverage is made in accordance with this plan, the student must meet the minimum eligibility requirements. If the request is approved, the coverage will be retroactive to the date of the qualifying event.

If the Coverage Status Change Form to terminate coverage is made in accordance with the Plan and approved, the termination will be effective the first day of the following coverage period and there will be no pro-rata refund of premium (during the term of the qualifying event).

If a student misses the 31 day deadline, the next opportunity to change Coverage Status will be at the beginning of the next policy year.

Coverage Status Change Forms are available from the Student Health Insurance office, or online at http://www.shi.osu.edu under Important Forms.

Section 4: Extension of Benefits after Termination

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

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

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

Section 5: Pre-Admission Notification

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

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

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

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

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

Section 6: Select Provider, Preferred Provider and Out-of-Network Provider Information

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

Select Providers are OSU Health Plan Network providers in Franklin County and UnitedHealthcare Options PPO providers outside Franklin County.

OSU Health Plan Network inside Franklin County: https://osuhealthplan.com/find-a-provider-search

Preferred Providers are UnitedHealthcare Options PPO providers inside Franklin County.

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

For questions about Provider Listings, please contact:

OSU Health Plan
(614) 292-4700 or

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

A provider's status may change. Insureds should always confirm that a provider is participating at the time services are required by calling OSU Health Plan at 1-614-292-4700 or HealthSmart at 1-844-206-0374 and/or by asking the provider when making an appointment for services. A directory of providers is available on the plan's website at www.uhcsr.com/osu.

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

If an Insured is currently receiving treatment for Covered Medical Expenses from a provider whose network status changes from Preferred Provider to Out-of-Network Provider during such treatment due to termination (non-renewal or expiration) of the provider's contract, the Insured may be eligible to request continued care from their current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes.

This continued care option is available to an Insured who is a continuing care patient who is:

- Undergoing a course of treatment for a serious and complex medical condition defined as:
  - An acute illness serious enough to require specialized medical treatment to avoid the possibility of death or permanent harm.
  - A chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and that requires specialized medical care over a prolonged time period.
- Undergoing a course of institutional or Inpatient care.
- Scheduled to undergo non-elective surgery (and post-operative care).
- Pregnant and undergoing a course of treatment for the pregnancy.
- Receiving treatment for a terminal illness.

This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud.

Continuity of care benefits are available for 90 days following the date the Insured receives notice of the provider's status change. This period will end earlier if the Insured ceases to receive care from the that provider.

An Insured may call the Company at 1-844-206-0374 to find out if they are eligible for continuity of care benefits.

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

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

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

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, unless otherwise stated in the Federal "No Surprises Act."

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

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

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

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

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

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

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

Section 7: Medical Expense Benefits

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

Benefits are subject to: 1) the maximum amount for specific services as set forth in the Schedule of Benefits; and 2) any Policy Deductible, Coinsurance, or Copayment amounts set forth in the Schedule of Benefits.

Benefits are payable for Covered Medical Expenses (see Definitions) less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness.

The total payable for all Covered Medical Expenses shall be calculated on a per Insured Person per Policy Year basis as stated in the Schedule of Benefits. **Read the Definitions section and the Exclusions and Limitations section carefully.**

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

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits.

Refer to the Exclusions and Limitations section of the Policy for any Exclusion or Limitation which may apply.

If a benefit is designated, Covered Medical Expenses include:

ESSENTIAL HEALTH BENEFITS: The following benefits are considered Essential Health Benefits.

Inpatient

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

   Benefits also include a private room rate when Medically Necessary.

2. **Intensive Care.**
   Services and nursing care provided when the Insured is confined to an Intensive Care unit specifically designed for the treatment of critically ill or injured patients.

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

   Benefits will be paid for services and supplies, including but not limited to:
   - The cost of the operating room.
   - Laboratory tests.
   - X-ray examinations.
   - Anesthesia.
   - Drugs (excluding take home drugs) or medicines.
   - Therapeutic services.
   - Medical and surgical dressings, supplies, casts, and splints.

4. **Routine Newborn Care.**
   While Hospital Confined and routine nursery care provided immediately after birth.

   Benefits will be paid for an inpatient stay of at least:
   - 48 hours following a vaginal delivery.
   - 96 hours following a cesarean section delivery.

   If the mother agrees, the attending Physician may discharge the newborn earlier than these minimum time frames.

   Benefits do not include routine Newborn Infant care and related Physician charges provided on an outpatient basis.

5. **Surgery.**
   Physician's surgery fees in connection with Inpatient surgery. Benefits include normal post-operative care.

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

7. **Anesthetist Services.**
   Professional services by an anesthetist when services are administered in connection with Inpatient surgery.

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

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

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

10. **Pre-admission Testing**.

Benefits are limited to routine tests, including but not limited to:

- Complete blood count.
- Urinalysis.
- Chest X-rays.

If otherwise payable under the Policy, major diagnostic procedures such as those listed below will be paid under the Hospital Miscellaneous benefit:

- CT scans.
- NMR's.
- Blood chemistries.

Outpatient

11. **Surgery.**
Physician's surgery fees in connection with outpatient surgery. Benefits include normal post-operative care.

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

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

14. **Anesthetist Services.**
Professional services by an anesthetist when services are administered in connection with outpatient surgery.

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

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

16. **Physiotherapy.**
Includes but is not limited to the following rehabilitative services (including Habilitative Services):

- Physical therapy, including treatment by physical means, hydrotherapy, heat, or similar modalities. Such therapy is given to relieve pain, restore function, and to prevent disability following a Sickness, Injury, or loss of limb.
- Occupational therapy for the treatment of a physically disabled Insured Person to promote the restoration of the Insured Person’s ability to satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Insured Person’s occupation.
- Cardiac rehabilitation therapy to restore an Insured Person’s functional status after a cardiac event.
- Manipulative treatment for treating problems associated with bones, joints, and the back.
- Speech therapy for the correction of a speech impairment.

Benefits do not include:

- Admission to a Hospital mainly for physical therapy.
- Long term rehabilitation in an Inpatient setting.

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

See also Benefits for Habilitative Services.

17. **Medical Emergency Expenses.**
Benefits will be provided for Emergency Services required to stabilize an Insured for a Medical Emergency.

Emergency Services means with respect to a Medical Emergency:

- A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Such further medical examination and treatment to Stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

With respect to Emergency Services, "stabilize" means medical treatment as may be necessary to assure, within reasonable medical probability, that:

- No material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.
- With respect to a pregnant woman who is having contractions, the pregnant woman will not deliver (including the placenta).

Emergency Services are available 24 hours per day, seven days per week. In the event of an emergency, the Insured should go to the nearest Hospital or use emergency services, including calling 911 or other telephone access systems utilized to contact pre-hospital emergency services, when appropriate for treatment of a Medical Emergency.

Medical Emergency benefits do not include follow-up care following an emergency room visit.

Refer to Section 6: Preferred Provider Information for additional information and a description of how Out-of-Network Emergency Services are processed.

18. **Diagnostic X-ray Services.**
Diagnostic X-rays are x-ray and other radiological services performed when the Insured has specific symptoms, to detect or monitor the Insured's condition. X-ray services for preventive care are provided as specified under Preventive Care Services.

Benefits include, but are not limited to:
- X-rays.
- Advanced Diagnostic Imaging, including MRA, MRI.
- Ultrasound.
- Nuclear diagnostic services, including nuclear cardiology imaging, PET scans, ad CT scans.
- Bone density studies.
- Professional services for the reading or interpretation of the images.
- Central supply (IV tubing) or pharmacy (dye) necessary to perform tests.

19. **Radiation Therapy.**
Benefits are provided for the treatment of a Sickness by x-ray, radium, cobalt, or radioactive isotopes, including:
- Teletherapy.
- Brachytherapy.
- Intraoperative radiation.
- Photon or high energy particle sources.
- Materials and supplies used in therapy.
- Treatment planning.

20. **Laboratory Procedures.**
Laboratory Procedures and pathology services. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

Benefits include the professional services for the interpretation of the lab results.

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

- X-rays.
- Laboratory Procedures.

The following tests and therapies will be paid under the Tests and Procedures (Outpatient) benefit:
- Inhalation therapy for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation into the lungs.
- Infusion therapy for the intravenous administration of pharmaceuticals, including but not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management, and chemotherapy.
- Pulmonary therapy to restore an Insured Person's pulmonary functional status after a Sickness or Injury.
- Respiratory therapy.
- Dialysis and hemodialysis for an acute or chronic kidney ailment.
- Cardiographic, encephalographic, and radioisotope tests.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocardiograms (EKG).
- Electromyograms (EMG).
- Electrocorticograms.
- Echocardiograms.
- Echographies.
- Doppler studies.
- Central supply (IV tubing) or pharmacy (dye) necessary to perform tests.

Benefits also include professional services for the reading and interpretation of the test or procedure.

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

22. **Injections.**
When administered in the Physician's office and charged on the Physician's statement for the treatment of a covered Injury or Sickness.

Immunizations for preventive care are provided as specified under Preventive Care Services.

Benefits do not include routine or preventive immunizations or preventive medicines or vaccines, except where required for the treatment of a covered Injury.

23. **Chemotherapy.**
Benefits are provided for the treatment of a Sickness by chemical or biological antineoplastic agents.

24. **Prescription Drugs.**
As specified in the HealthSmart RX Prescription Drug Benefits section.

Benefits will be provided at the benefit levels indicated in the Schedule of Benefits.

Other

25. **Ambulance Services.**
Benefits include Medically Necessary transportation to and from the nearest facility in a vehicle (including ground, water, fixed wing, and rotary wing air transportation) which is:
- Specifically designed to transport a sick or injured person.
- Staffed by properly trained medical professionals.

Ambulance services include transportation:
- From the Insured's home, scene of accident or Medical Emergency to a Hospital.
- Between Hospitals.

- Between a Hospital and Skilled Nursing Facility.
- From a Hospital or Skilled Nursing Facility to an Insured's home.

Ambulance services also include Medically Necessary treatment of a Sickness or Injury received from a medical professional working on an ambulance when the Insured is not transported.

Benefits do not include transportation:
- To a Physician's office or clinic.
- To a morgue or funeral home.

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

Benefits also may include but are not limited to the following items when Medically Necessary:
- Hemodialysis equipment.
- Crutches and replacement of pads and tips.
- Pressure machines.
- Infusion pumps for IV fluids and prescription medications.
- Tracheotomy tube.
- Cardiac, neonatal, and sleep apnea monitors.
- Augmentive communications devices when necessary for an Insured's specific condition.

Costs associated with the delivery, installation, and repair of durable medical equipment are considered to be Covered Medical Expenses.

For the purposes of this benefit, the following are also considered durable medical equipment.
- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices, including composite facial prosthesis, that replace a limb or body part but does not include any device that is fully implanted into the body.
- Orthotic devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, including the cost of initial purchase, fitting, and repair of rigid or semi-rigid devices.
- Custom made shoe inserts, ankle foot orthotics, or built-up shoe.
- Back and special surgical corsets, trusses, and supports.
- Splints (extremity), wristlets, and slings.
- Cervical collars.
- Cochlear implants.

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

Benefits not covered include, but are not limited to:
- Air conditioners.
- Ice bags/coldpack pump.
- Raised toilet seats or tub chair for use in the shower.
- Translift chairs.
- Treadmill exerciser.
- Dentures or dental appliances.
- Non-rigid appliances, such as elastic stockings, garter belts, and corsets.
- Artificial heart implants.

- Penile prosthesis in men suffering from impotency.
- Orthopedic shoes.
- Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.

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

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:
- Injury to Sound, Natural Teeth.
- Facility charges for outpatient services if the Insured's medical condition or a dental procedure requires a Hospital setting to ensure the safety of the Insured.
- X-rays, supplies, appliances and all associated Covered Medical Expenses, including Hospital facility charges and anesthesia for transplant preparation, initiation of immunosuppressives, direct treatment of acute traumatic Injury, cancer, or cleft palate.

Benefits for accidental dental Injury include, but are not limited to:
- Oral examination.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular/maxillary reconstruction.
- Anesthesia.

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

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

29. **Mental Illness Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- At a Residential Treatment Facility.
- On an outpatient basis including intensive outpatient treatment.

Benefits do not include services received for:
- Custodial or domiciliary care.
- Services or care provided or billed by a residential treatment center, school, halfway house, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- Supervised living or halfway houses.

See also Benefits for Biologically Based Mental Illness.

30. **Substance Use Disorder Treatment.**
Benefits will be paid for services received:
- On an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital.
- At a Residential Treatment Facility.
- On an outpatient basis including intensive outpatient treatment.

The Insured may access educational materials about opioid abuse and other treatment options from the following resources:

- Take Charge Ohio. Website: TakeChargeOhio.org
- Ohio Department of Mental Health and Addiction Services. Website: mha.ohio.gov
- Substance Abuse and Mental health Services Administration. Website: samhsa.gov

The Insured is encouraged to contact the Company to find the appropriate type of Preferred Provider who provides treatment for high-risk Insureds with opioid use disorder. For assistance locating a Preferred Provider, the Insured may contact the Company toll free at 1-844-206-0374. In addition, the Company's utilization review program provides 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.

Benefits do not include services received for:
- Caffeine addiction.
- Non-chemical addiction, such as gambling, sexual, spending, shopping, working, and religious.
- Custodial or domiciliary care.
- Services or care provided or billed by a residential treatment center, school, halfway house, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- Supervised living or halfway houses.

31. **Maternity.**
Same as any other Sickness for prenatal and postnatal maternity care.

Benefits will be paid for an inpatient stay of at least:
- 48 hours following a vaginal delivery.
- 96 hours following a cesarean section delivery.

If the mother agrees, the attending Physician or certified nurse midwife may discharge the mother earlier than these minimum time frames.

See also Benefits for Maternity Follow-Up Care.

Benefits for therapeutic abortion are provided only when the therapeutic abortion is performed:
- To save the life of the mother.
- As a result of a case of rape or incest.

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

33. **Preventive Care Services.**
Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Required preventive care services are updated on an ongoing basis as guidelines and recommendations change. The complete and current list of preventive care services covered under the health reform law can be found at:

https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

Benefits include coverage for one option for each of the FDA-approved contraceptive categories defined under the Health Resources and Services Administration (HRSA) requirement. If an Insured Person's Physician recommends a particular contraceptive service or FDA-approved item based on a determination of Medical Necessity, coverage for that contraceptive service or item will be provided under the Preventive Care Services benefit.

Benefits do not include any other:
- Routine preventive care immunizations.
- Routine physical examinations and testing.

- Preventive testing or treatment.
- Screening exams or testing in the absence of Injury or Sickness.

See also Benefits for Child Health Supervision Services.

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

Benefits include:
- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of mastectomy, including lymphedemas.
- Post-mastectomy surgical bras limited to four (4) bras per Policy Year.

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

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

Benefits also include preventive foot care for Insured Persons with diabetes.

36. **Home Health Care.**
Services received from a licensed home health agency that are:
- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person's home.
- Pursuant to a home health plan.
- Provided when an Insured is confined to the home for medical reasons and physically unable to obtain needed medical services.

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.

Home Health Care services also include:
- Diagnostic services.
- Nutritional guidance.
- Home health aide services.
- Prescription Drugs (only if provided and billed by a home health care agency).
- Infusion therapy for the in-home intravenous administration of pharmaceuticals, including but not limited to injections (intra-muscular, subcutaneous, continuous subcutaneous), total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management, and chemotherapy.
- Nursing services only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider.
- Private Duty Nursing services, such as teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supporting care.

For the purposes of this benefit "Private Duty Nursing" means skilled nursing service provided on a one-to-one basis by an actively practicing Registered Nurse (R.N.) or licensed practical nurse (L.P.N). Private duty nursing is shift nursing of eight hours or greater per day and does not include nursing care of less than eight hours per day. Private duty nursing does not include Custodial Care services.

Home Health Care services do not include:
- Food, housing, homemaker services, or home delivered meals.
- Physician charges.

- Cost or installation of helpful environmental materials, services, appliances, or devices. (i.e. hand rails, ramps, air conditioners)
- Services provided by the Insured's immediate family.
- Services provided by volunteer ambulance associations for which the Insured is not required to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

37. **Hospice Care.**
When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. Benefits will continue if the Insured Person lives longer than six months. All hospice care must be received from a licensed hospice agency.

Hospice care includes:
- Services provided in the home or at an Inpatient hospice facility.
- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.
- Nursing services.
- Home health aide services.
- Prescription drugs given by the hospice facility.

Hospice care does not include:
- Volunteer services.
- Housekeeping services.

38. **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.

Benefits include a day rehabilitation therapy program for Insureds who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day at a Day Hospital. Day rehabilitation program services may consist of physical therapy, occupational therapy, speech therapy, nursing services, and neuropsychological services. A minimum of two therapy services must be provided for this program to be a Covered Medical Expense.

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

40. **Urgent Care Center.**
Benefits are limited to the facility or clinic fee billed by the Urgent Care Center.

All other services rendered during the visit will be paid at the benefit levels specified in the Schedule of Benefits based on the type of covered service performed.

41. **Hospital Outpatient Facility or Clinic.**
Benefits are limited to the facility or clinic fee billed by the Hospital.

All other services rendered during the visit will be paid at the benefit levels specified in the Schedule of Benefits based on the type of covered service performed.

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

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

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

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Healthcare Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA).
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review. The peer review system is determined by the Secretary of Health and Human Services to meet both of the following criteria:
    - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health.
    - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

See also Benefits for Cancer Clinical Trials.

43. **Transplantation Services.**
Same as any other Sickness for Medically Necessary human organ, tissue, stem cell / bone marrow transplants and transfusions when ordered by a Physician. Benefits include acquisition procedures, harvest and storage, and Medically Necessary preparatory myeloablative therapy. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs directly related to the procurement of an organ or tissue from a live donor, including complications from the donor procedure for up to six weeks after the date of procurement, are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under the Policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require the Policy to be primary.

Benefits also include:

- Reasonable and necessary transportation and lodging expenses for the Insured and a donor companion/caregiver when the Insured has to travel more than 75 miles from their residence, up to a maximum benefit of $10,000 per transplant.
- Unrelated donor searches for bone marrow and stem cell transplants.

No benefits are payable for:

- Transplants which are considered an Elective Surgery or Elective Treatment (as defined).
- Transplants involving permanent mechanical or animal organs.
- Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person.

44. **Pediatric Dental and Vision Services.**
Benefits are payable as specified in the Pediatric Dental Services Benefits and Pediatric Vision Care Services Benefits sections.

45. **Reconstructive Procedures.**
Benefits are provided for reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, Sickness, Injury, or an earlier treatment in order to create a more normal appearance. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Medical Expense under this Policy.

See also Reconstructive Breast Surgery following a Mastectomy.

Benefits are not provided for services performed where the primary result of the procedure is a changed or improved physical appearance.

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

Benefits include:
- Allergy testing.
- Allergy injections.
- Allergy serum extracts.

47. **Gender Dysphoria Treatment.**
Benefits for gender dysphoria treatment are provided at the benefits levels specified in the Schedule of Benefits based on the type of covered service performed. Coverage is based on the Company's current medical policies and coverage determination guidelines on Gender Dysphoria Treatment. For more information go to www.uhcsr.com/osu and then click on the "Additional Info" box in the center of the page.

Follow the link –"Coverage Determination Guideline" for Gender Dysphoria (Gender Identity Disorder) Treatment. Company medical policies and guidelines are subject to change. Use the link and instructions above for the Coverage Determination Guideline on Gender Dysphoria Treatment.

48. **Male Sterilization.**
Benefits for male sterilization are provided at the benefit levels specified in the Schedule of Benefits based on the type of covered service performed.

49. **Medical Supplies.**
Medical supplies must meet all of the following criteria:
- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

Benefits are limited to a 31-day supply per purchase.

Benefits do not include:
- Any comfort, luxury, or convenience items.
- Items which exceed the Medical Necessity needs of the Insured.
- Items usually stocked in the home for general use, such as bandages, thermometers, adhesive tapes, hot packs, ice bags.

50. **Ostomy Supplies.**
Benefits for ostomy supplies may include, but are not limited to:
- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for:

- Deodorants.
- Filters.
- Lubricants.
- Tape.
- Appliance cleaners.
- Adhesive or adhesive remover.

51. **Temporomandibular Joint Disorder.**
Same as any other Sickness for treatment of temporomandibular joint disorder and craniomandibular joint disorder.

52. **Vision Correction.**
Benefits are payable for the following:
- When due to a covered Injury or Sickness.
- The first pair of eyeglasses or contact lenses following intraocular lens implantation for the treatment of cataracts or aphakia.
- To replace the function of the human lens for conditions caused by cataract surgery or Injury.

Benefits do not include any other:
- Routine eye examinations.
- Eye refractions.
- Eyeglasses.
- Contact lenses.
- Prescriptions or fitting of eyeglasses or contact lenses.

Vision correction for preventive care is provided under Preventive Care Services.

53. **Wigs.**
Wigs and other scalp hair prosthesis as a result of hair loss due to cancer treatment.

Benefits are limited to the first wig following cancer treatment not to exceed one per Policy Year.

NON-ESSENTIAL HEALTH BENEFITS. The following benefits are considered to be non-Essential Health Benefits.

1. **Acupuncture.**
Benefits will be paid for acupuncture at the benefit levels indicated in the Schedule of Benefits limited to a maximum of 10 visits per Policy Year.

2. **Elective Abortion.**
Benefit will be paid for elective abortion at the benefit levels indicated in the Schedule of Benefits. Graduate associates or fellows receiving a premium subsidy from The Ohio State University are not eligible for this benefit.

3. **Non-Prescription Enteral Formula.**
Benefits will be paid for non-prescription enteral formula at the benefit levels indicated in the Schedule of Benefits. Benefits are limited to non-prescription enteral formulas for which a Physician has issued a written order and are for the treatment of malabsorption caused by any of the following:
- Crohn's Disease.
- Ulcerative colitis.
- Gastroesophageal reflux.
- Gastrointestinal motility.
- Chronic intestinal pseudo obstruction.
- Inherited diseases of amino acids and organic acids.

Benefits for inherited diseases of amino acids and organic acids also include food products modified to be low protein.

4. **Routine Eye Exam.**

Except as provided in the policy for Pediatric Vision Services, benefits will be paid for one routine eye exam per Policy Year at the benefit level indicated in the Schedule of Benefits, subject to the benefit maximum specified in the Schedule of Benefits.

5. **Human Organ Transplant Donor Search.**
   Except as provided in the policy for Transplantation Services, benefits will be paid for human organ transplant donor search at the benefit level indicated in the Schedule of Benefits, subject to the benefit maximum specified in the Schedule of Benefits.

Section 8: Mandated Benefits

BENEFITS FOR BIOLOGICALLY BASED MENTAL ILLNESS

Benefits will be paid the same as any other Mental Illness for the treatment of Biologically Based Mental Illness.

Benefits will be provided if both of the following apply:

1. The Biologically Based Mental Illness is clinically diagnosed by a Physician authorized to practice medicine and surgery or osteopathic medicine and surgery, a psychologist, a professional clinical counselor, professional counselor, independent social worker, or a clinical nurse specialist whose nursing specialty is mental health.
2. The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

"Biologically Based Mental Illness" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

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

BENEFITS FOR CANCER CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for Routine Patient Care administered to an Insured participating in any stage of an Eligible Cancer Clinical Trial, if those expenses would be paid if the Insured was not participating in a clinical trial.

"Eligible Cancer Clinical Trial" means a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
2. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
4. The trial does one of the following:
   - Tests how to administer a health care service, item, or drug for the treatment of cancer.
   - Tests responses to a health care service, item or drug for the treatment of cancer.
   - Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items or drugs for the treatment of cancer.
   - Studies new uses of a health care service, item, or drug for the treatment of cancer.
5. The trial is approved by one of the following entities:
   - The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services.
   - The United States Department of Defense.
   - The United States Department of Veterans' Affairs.

"Routine Patient Care" means all health care services consistent with the coverage provided in the policy for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a Cancer Clinical Trial, and that was not necessitated solely because of the trial.

Benefits will not be paid for:

1. A health care service, item, or drug that is the subject of the cancer clinical trial.
2. A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
3. An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
4. Transportation, lodging, food, or other expenses for the Insured, or a family member of companion of the Insured, that are associated with the travel to or from a facility providing the cancer clinical trial;
5. An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
6. A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsors of the cancer clinical trial.

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

BENEFITS FOR MATERNITY FOLLOW-UP CARE

Benefits shall be provided for maternity follow-up care when directed by a Physician or an advanced practice registered nurse for a mother and her newborn. Benefits shall include:

1. Physical assessment of the mother and newborn.
2. Parent education.
3. Assistance and training in breast or bottle feeding.
4. Assessment of the home support system.
5. Performance of any Medically Necessary and appropriate clinical tests.
6. Any other services consistent with follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Benefits apply to services provided in a medical setting or through home health care visits when such visits are performed by a provider who is knowledgeable and experienced in maternity and newborn care.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, then benefits will be paid for follow-up care that is provided within seventy-two (72) hours after discharge. When the mother or newborn receive at least the number of hours in inpatient required to be covered, then benefits will be paid for Medically Necessary follow-up care as determined by the health care provider responsible for discharging the mother or newborn.

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

BENEFITS FOR CYTOLOGIC SCREENING AND SCREENING MAMMOGRAPHY

Benefits shall be provided for Screening Mammography to detect the presence of breast cancer in adult women and cytologic screening for the presence of cervical cancer.

Benefits for Screening Mammography shall be provided:

1. For a woman at least age thirty-five (35) but under age forty, one Screening Mammography.
2. For a woman at least age forty (40) but under age fifty (50), either of the following:
   - One Screening Mammography every two (2) years; or
   - One Screening Mammography every year if a Physician has determined that the woman has risk factors for breast cancer.
3. For a woman at least age fifty (50) but under age sixty-five (65), one Screening Mammography every year.

“Screening Mammography” means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic women and includes the x-ray examination for the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than on rad mid-breast. Screening Mammography includes two views for each breast and the professional interpretation of the film. Screening Mammography does not include a diagnostic mammography.

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

Cytologic screenings not covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be subject to all Preferred Provider Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

Cytologic screenings not covered by the Preventive Care Services Benefit and received from an Out-of-Network Provider shall be subject to all Out-of-Network Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

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

Screening Mammography not covered by the Preventive Care Services Benefit shall be covered for a total not more than 130% of the Medicare Reimbursement Rate in Ohio for screening mammography. No provider, Hospital, or other health care facility shall seek or receive compensation in excess of 130% of the Medicare reimbursement rate, except for applicable Deductibles and Copayments. Benefits shall be subject to all limitations or any other provisions of the Policy.

"Medicare Reimbursement Rate" means the reimbursement rate paid in Ohio under the Medicare program for Screening Mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

BENEFITS FOR ORAL ANTICANCER MEDICATION

Benefits will be provided for prescribed, orally administered anticancer medication that has been approved by the Federal Food and Drug Administration and is used to kill or slow the growth of cancerous cells.

The orally administered medication shall be provided at a cost to the Insured not to exceed the Coinsurance percentage or the Copayment amount specified in the Schedule of Benefits for Chemotherapy which is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose.

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

BENEFITS FOR OFF LABEL USE OF PRESCRIPTION DRUGS

Benefits will be provided for any drug approved by the United States Food and Drug Administration, even though the drug has not been approved by the United States Food and Drug Administration for the treatment of the particular indication for which the drug has been prescribed, provided that the drug has been recognized as safe and effective for the treatment of that indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature that meets the specific criteria listed below.

Medical literature may be accepted for the purposes of this mandate, if all of the following apply:

1. Two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
2. No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
3. Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or is published in a journal specified by the United States Department of Health and Human Services pursuant to section 186(t)(2)(B) of the Social Security Act 107 Stat. 591 (1993), 42 U. S. C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature.

Nothing in this section shall:

1. Require coverage for any drug if the United States Food and Drug Administration has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed.
2. Require coverage for experimental drugs not approved for any indication by the United States Food and Drug Administration.

3. Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the United States Food and Drug Administration.
4. Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs for this policy.
5. Prohibit the application of any policy limitations or exclusions, provided that the decision is not based primarily on the basis that the coverage of the drug is required by this mandate.

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

BENEFITS FOR CHILD HEALTH SUPERVISION SERVICES

When the policy includes Dependent coverage, then benefits shall be provided the same as any other Sickness for Child Health Supervision Services from the moment of birth until age nine.

"Child Health Supervision Services" means periodic review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, or, in the case of hearing screening, by an individual conducting a hearing screening on a newborn infant in a Hospital.

Child Health Supervision Services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule of Benefits.

Child Health Supervision Services not covered by the Preventive Care Services Benefit shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR HABILITATIVE SERVICES

Benefits will be provided the same as any other Mental Illness for Habilitative Services provided to an Insured Person up to age 21 with a medical diagnosis of Autism Spectrum Disorder.

Benefits include, but are not limited to:

1. Outpatient physical rehabilitation services, including:
   - Speech and language therapy and occupational therapy, performed by a licensed therapist.
   - Clinical therapeutic intervention defined as therapies supported by empirical evidence, which includes but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the state to perform the services in accordance with a treatment plan.
2. Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or physician to provide consultation, assessment, development and oversight of treatment plans.

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

Section 9: Coordination of This Contract's Benefits with Other Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one **Plan.** **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** does not exceed 100% of the total **Allowable expense**.

DEFINITIONS

A. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) **Plan** includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
(2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

B. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**.

When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:
(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.
(2) If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
(3) If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
(4) If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides 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, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
(5) The amount of any benefit reduction by the **Primary plan** because a covered 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 admissions, and preferred provider arrangements.

E. **Closed panel plan** is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

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

B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
(2) 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.

C. 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**.

D. Each **Plan** determines its order of benefits using the first of the following rules that apply:
(1) Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:
(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
• The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
• If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.
• However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
• The **Plan** covering the **Custodial parent**;
• The **Plan** covering the spouse of the **Custodial parent**;
• The **Plan** covering the **non-custodial parent**; and then
• The **Plan** covering the spouse of the **non-custodial parent**
(c) For a dependent child covered under more than one **Plan** of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
(3) Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have

this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When **This plan** is secondary, it may reduce its 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 any **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.

B. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. HealthSmart may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. HealthSmart need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give HealthSmart any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by HealthSmart is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Call our Customer Service Department at 1-844-206-0374. If you are still not satisfied, you may call the Ohio Department of

Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at *http://insurance.ohio.gov*.

Section 10: Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

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

Life	$ 10,000.00
Two or More Members	$ 10,000.00
One Member	$ 5,000.00
Thumb or Index Finger	$ 2,500.00

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.

Section 11: Definitions

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

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

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

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

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

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

Allowed amounts are based on the following:

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

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

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

- The initial payment made by the Company or the amount subsequently agreed to by the Out-of-Network Provider and the Company.
- The amount determined by *Independent Dispute Resolution (IDR)*.

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

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

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

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

1. Negotiated rates agreed to by the Out-of-Network Provider and either the Company or one of Our vendors, affiliates or subcontractors.
2. If rates have not been negotiated, then one of the following amounts:
   - Allowed amounts are determined based on 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographical market, with the exception of the following.
     - 50% of CMS for the same or similar freestanding laboratory service.
     - 45% of CMS for the same or similar Durable Medical Equipment from a freestanding supplier, or CMS competitive bid rates.
     - 70% of CMS for the same or similar physical therapy service from a freestanding provider.
   - When a rate for all other services is not published by CMS for the service, the allowed amount is based on 20% of the provider's billed charge.

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

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

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

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

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

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

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

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

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

Covered medical expenses include the Preventive Care Services described in the Medical Expense Benefits section of this Certificate.

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.

DAY HOSPITAL means a facility that provides day rehabilitation services on an outpatient basis.

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

DEPENDENT means:

1. The legal spouse of the Named Insured
2. The Domestic Partner of the Named Insured.
3. Their dependent children.

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

The 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 intellectual disability or physical handicap.
2. Chiefly dependent upon the Insured Person for support and maintenance.

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

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

DOMESTIC PARTNER means a person who meets the requirements of a domestic partnership with the Named Insured, as defined by the Policyholder, in accordance with local government authorities in Ohio that recognize domestic partnerships. Proper evidentiary documentation that meets the local government requirements may be required by the Policyholder.

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

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

1. An appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition.
2. Such further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided).

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

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

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

ESSENTIAL HEALTH BENEFITS means the following general categories and the items and services covered within the categories:

1. Ambulatory patient services.
2. Emergency Services.
3. Hospitalization.
4. Maternity and newborn care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Prescription drugs.
7. Rehabilitative and habilitative services and devices.
8. Laboratory services.
9. Preventive wellness services and chronic disease management.
10. Pediatric services, including oral and vision care.

Essential health benefits shall be consistent with benefits set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

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

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

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

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of 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 on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

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

INJURY means bodily injury which is all of the following:

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

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

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

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

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

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

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

MEDICAL EMERGENCY means a medical condition (including Mental Illness and Substance Use Disorder) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an

average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention would result in any of the following:

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

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

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

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

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

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

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

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

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

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

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 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 31 days after the child's birth.

OUT-OF-NETWORK PROVIDER means a provider who has not contracted with the Company and has not agreed to provide specific services on any prearranged fee schedule. The Insured Person will pay a higher amount of cost sharing to see an out-of-network provider.

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts (including but not limited to, other practitioners such as a physician's assistant or registered nurse) who provides care within the scope of his/her license, other than a member of the person's immediate family.

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

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

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

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

POLICY YEAR means the academic year beginning on the Policy Effective Date and ending on the Policy Termination Date.

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

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

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

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

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

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

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

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

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

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

RESIDENTIAL TREATMENT FACILITY means a facility operating as required by law that provides Mental Illness and Substance Use Disorder treatment. A residential treatment facility must meet all the following requirements:

1. Provide a program of treatment under active participation and direction of a Physician.

2. Have or maintain a written, specific and detailed treatment program requiring the Insured's full-time residence and participation.
3. Provide at least the following basic services in a 24-hour per day, structured setting:
   - Room and board.
   - Evaluation and diagnosis.
   - Counseling.
   - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a Hospital will be considered to be a Hospital.

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

SELECT PROVIDER means a Preferred Provider where the Insured Person will receive the highest level of benefits available under the Policy.

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

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

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

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

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

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

Section 12: Exclusions and Limitations

This Exclusions and Limitations section describes items which are excluded from coverage and are not considered to be Covered Medical Expenses.

Read the Definitions section and the attached Schedule of Benefits carefully. Refer to the Medical Expense Benefits section for benefit specific limitations.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for procedures, equipment, services, supplies, or charges which the Company determines are not Medically Necessary or do not meet the Company's medical policy, clinical coverage guidelines, or benefit policy guidelines.

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. Cosmetic procedures. Cosmetic procedures are primarily intended to preserve, change, or improve the Insured Person's appearance, including surgery or treatments to change the size, shape, or appearance of facial or body features (such as the Insured's skin, nose, eyes, ears, cheeks, chin, chest, or breasts).
   This exclusion does not apply to:
   - Benefits specifically provided in the Policy for Reconstructive Procedures.
   - Myocardial infarction.
   - Pulmonary embolism.

- Thrombophlebitis.
- Exacerbations of co-morbid conditions.

2. 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.
3. Any dental treatment not specifically provided for in the Policy.
4. Elective Surgery or Elective Treatment.
5. Examinations related to research screenings.
6. Routine foot care including the care, cutting and removal of corns, calluses and toenails.
7. Health spa or similar facilities. Strengthening programs.
8. Hearing aids or exams to prescribe or fit them.
9. Hypnosis.
10. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
11. Injury sustained from playing, practicing, traveling to or from, participating in, or conditioning for any intercollegiate sport for which benefits are paid or payable under a sports accident policy issued to the Policyholder, or for which coverage is provided by the National Collegiate Athletic Association (NCAA), the National Association of Intercollegiate Athletics (NAIA), or any other sports association.
12. Investigational services.
13. Direct participation in a riot or civil disobedience, nuclear explosion, or nuclear accident. Commission of or attempt to commit a felony.
14. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, or for licensing.
15. Prescription Drugs, services or supplies as follows:
    - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, not specifically provided for in the Policy.
    - Immunization agents, except as specifically provided under Preventive Care Services.
    - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
    - Products used for cosmetic purposes.
    - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
    - Anorectics - drugs used for the purpose of weight control.
    - Fertility agents or sexual enhancement drugs.
    - Growth hormones.
    - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
16. Reconstructive procedures, except as specifically provided in the benefits for Reconstructive Procedures.
17. Reproductive services for the following:
    - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception.
    - Reversal of sterilization procedures.
18. When the Policyholder has a Student Health Center, services provided by the Student Health Center for which the Insured Person has no legal obligation to pay.
19. Surgical treatment of gynecomastia.
20. Services provided by any Governmental unit, unless otherwise required by law or regulation.
21. 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).
22. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in benefits for Preventive Care Services.

Section 13: How to File a Claim for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. If the Insured Person is submitting the claim and a claim form is not required, mail to the address below all medical and hospital bills along with the patient's name and Insured student's name, address, SR ID number (Insured’s insurance Company ID number) and name of the college or university under which the student is insured.
2. If the Insured Person is submitting the claim and a claim form is required, secure a Company claim form from the address below, fill in the necessary information, have the attending physician complete his portion of the form, if

required, attach all medical and hospital bills and mail to the address below. If a claim form is required, no claim will be paid unless a Company claim form is filled out completely and mailed to the address below.

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

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

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
1-844-206-0374

Section 14: General Provisions

GRACE PERIOD: A grace period of thirty-one days will be granted for the payment of any premium due except the first premium. Coverage shall continue in force during this grace period unless the Policyholder has given the Company written notice of discontinuance in accordance with the terms of the Policy and in advance of the date of discontinuance.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, 3320 West Market Street, Suite 100, Fairlawn, OH 44333-3306 with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

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

TIME OF PAYMENT OF CLAIM: Indemnities payable under the Policy for any loss will be paid immediately or within 30 days upon receipt of due written proof of such loss.

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

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

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

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 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.

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

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

If the full value of an Insured Person's recovered amount is reduced due to: 1) comparative negligence; 2) a party's liability under sections 2307.22 to 2307.28 of the revised code; 3) the collectability of the full value of the claim for injury, death, or

loss resulting from limited liability insurance; or 4) any other cause, then the Company's recoverable amount shall be diminished in the same proportion as the Insured Person's.

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

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

Section 15: Notice of Appeal Rights

RIGHT TO INTERNAL APPEAL
Standard Internal Appeal

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

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

Please contact the Customer Service Department at 1-844-206-0374 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: HealthSmart Benefit Solutions, Inc., 3320 West Market Street, Suite 100 Fairlawn, OH 44333-3306.

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 three working days after receipt of the grievance, the Company shall provide notice that the Insured Person or Authorized Representative is entitled to:
1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Insured Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:
1. Any new or additional evidence considered by the Company in connection with the grievance; and
2. Any new or additional rationale upon which the decision was based.

The 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 48 hours for an Urgent Care Request or 10 days for a non-Urgent Care Request 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 of the health care provider; and
   c. The claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Insured Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
   a. The specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
   b. Reference to the specific Policy provisions upon which the determination is based;
   c. A statement that the Insured Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Insured Person's benefit request;
   d. If applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
   e. If the Final Adverse Determination is based on a Medical Necessity or experimental or investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Insured Person free of charge upon request;
   f. Instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. The Insured Person's right to bring a civil action in a court of competent jurisdiction; and
7. Notice of the Insured Person's right to contact the Superintendent's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time.

Expedited Internal Review

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

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

1. Could seriously jeopardize the life, health, or safety of the Insured Person or others due to the Insured's psychological state; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical or behavioral condition, subject the Insured Person to adverse health consequences without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact Claims Appeals at 1-844-206-0374. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, HealthSmart Benefit Solutions, Inc., 3320 West Market Street, Suite 100 Fairlawn, OH 44333-3306.

Expedited Internal Review Process

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

1. Involving Urgent Care 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 forty-eight (48) 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 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.

RIGHT TO EXTERNAL INDEPENDENT REVIEW

After exhausting the Company's Internal Appeal process, an Insured Person or Authorized Representative may submit a request for an External Independent Review when the service or treatment in question:

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 180 days 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 Company. Upon request of an External Review, the Company shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

Where to Send External Review Requests

All types of External Review requests shall be submitted to Claims Appeals at the following address:

Claims Appeals
HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
1-844-206-0374

Standard External Review (SER) Process

A Standard External Review request must be submitted in writing within 180 days of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

1. Within five 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 one business day after completion of the preliminary review, the Company shall notify the Superintendent, 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 Superintendent.
3. After receiving notice that a request is eligible for SER, the Superintendent shall, within one business day:
   a. Assign an Independent Review Organization (IRO) from the Superintendent'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 five 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 five 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 one business day, advise the Superintendent, 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 one 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 it decision, the Company shall provide written notification within one business day to the Superintendent, 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 30 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 Superintendent, 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.

Expedited External Review (EER) Process

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or an Authorized Representative may make a written or oral request for an Expedited External Review (EER) with the Company at the time the Insured Person receives:
   a. An Adverse Determination if:
      - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      - 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:
      - 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

- The Final Adverse determination involves an admission, availability of care, continued stay or health care service for which the Insured Person received Emergency Services, but has not been discharged from a facility.

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

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

Standard Experimental or Investigational Treatment External Review (SEIER) Process

An Insured Person, or an Insured Person's Authorized Representative, may submit a request for an Experimental or Investigational External Review when the denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational.

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 180 days of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

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 Company.
2. Within five 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:
      - 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
      - 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:
   - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
   - Standard health care services or treatments are not medically appropriate for the Insured Person;
   - 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:
   - 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
   - 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 one business day after completion of the preliminary review, the Company shall notify the Superintendent, 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 Superintendent.
4. After receiving notice that a request is eligible for SEIER, the Superintendent shall, within one business day:
   a. Assign an IRO from the Superintendent'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 five 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 five 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 Superintendent, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
6. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within one 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 it decision, the Company shall immediately provide written notification to the Superintendent, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SEIER.
8. After completion of the IRO's review, upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational Treatment External Review (EEIER) Process

An Insured Person, or an Insured Person's Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review when:

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 Company at the time the Insured Person receives:
   a. An Adverse Determination if:
      - The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      - 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:
      - 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
      - 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:
      - 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
      - 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:
      - Standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      - Standard health care services or treatments are not medically appropriate for the Insured Person;
      - 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:
      - 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
      - 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 sub-sections 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 Superintendent, 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 Superintendent.
4. After receiving notice that a request is eligible for EEIER, the Superintendent shall immediately:
   a. Assign an IRO from the Superintendent'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 five 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 Superintendent, 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 one 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 Superintendent, 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 five calendar days after being selected by the IRO.
11. The IRO shall make a decision and provide oral or written notice of its decision within 48 hours after receipt of the opinions from each clinical reviewer.
12. Upon receipt of the IRO's notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

EXTERNAL REVIEW BY THE OHIO DEPARTMENT OF INSURANCE

An Insured Person is entitled to an External Review by the Ohio Department of Insurance in either of the following circumstances:

1. The Adverse Benefit Determination is based on a contractual issue and did not involve a medical judgment or a determination based on medical information.
2. The Adverse Benefit Determination is based on the Company's determination that a medical condition did not meet the definition of Medical Emergency and the Company's decisions has already been upheld through an External Review by an IRO.

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 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.

APPEAL RIGHTS DEFINITIONS

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

Adverse Benefit Determination means a denial, reduction, or termination of, or failure to provide or make payment for a benefit, including denial, reduction, or termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to participate in a plan, and including denial, reduction, or termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. A rescission of coverage will also be considered to be an Adverse Benefit Determination.

Authorized Representative means:

1. A person to whom an Insured Person has given express written consent to represent the Insured Person;
1. A person authorized by law to provide substituted consent for an Insured Person;

2. An Insured Person's family member or health care provider when the Insured Person is unable to provide consent; or
3. 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, health, or safety of the Insured Person or others due to the Insured's psychological state; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person's medical or behavioral condition, subject the Insured Person to adverse health consequences 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.

Questions Regarding Appeal Rights
Contact Customer Service at 1-844-206-0374 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

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

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, Ohio 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Website: www.insurance.ohio.gov

Section 16: Online Access to Account Information

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

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

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

Section 17: Important Company Contact Information

The Policy is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Claims Status and all other Claim Inquires:
Claims Administrator
HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
1-844-206-0374
Email: OSUSHIPclaims@healthsmart.com

Customer Service:

- **1-844-206-0374**
- **(Customer Services Representatives are available Monday - Friday, 7:00 a.m. – 7:00 p.m. (Central Time))**

Section 18: Pediatric Dental Services Benefits

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

Section 1: Accessing Pediatric Dental Services

What Are Covered Dental Services?

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

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

What Is a Pre-Treatment Estimate?

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

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

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

Does Pre-Authorization Apply?

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are provided.

Pre-authorization requests will be responded to within 48 hours for Urgent Care Requests, or 10 calendar days for any pre-authorization request that is not for Urgent Care Requests. Our response will indicate whether the request is approved or denied. If the pre-authorization is denied, we will provide the specific reason for the denial.

If the request is denied, the Insured Person should refer to the Notice of Appeal Rights section of this Certificate for instructions on how to submit an appeal.

If the pre-authorization request is incomplete, we will indicate the specific additional information that is required to process the request.

If the Insured Person does not obtain a pre-authorization, benefits for orthodontic services will be subject to a reduction of $500 per occurrence.

Section 2: Benefits for Pediatric Dental Services

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

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

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

Benefits for Allowed Dental Amounts are determined as a percentage of the Usual and Customary Fees. The Insured Person must pay the amount by which the Dental Provider's billed charge exceeds the Eligible Dental Expense.

Dental Services Deductible

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

The Dental Services Deductible per Policy Year is $500 per Insured Person.

Out-of-Pocket Maximum - any amount the Insured Person pays in Coinsurance, for the Dental Services Deductible, and for the reduction for failure to obtain pre-authorization for pediatric Dental Services applies to the Out-of-Pocket Maximum stated in the Policy Schedule of Benefits.

Benefits

Dental Services Deductibles are calculated on a Policy Year basis.

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

Benefits for pediatric Dental Services are subject to a separate Dental Services Deductible.

Benefit Description

Benefit percentages shown below are the percentages of Covered Dental Services that the Company pays.

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
Diagnostic Services - (Subject to payment of the Dental Services Deductible.)	
Evaluations (Checkup Exams) Limited to 2 times per 12 months.	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
Covered as a separate benefit only if no other service was done during the visit other than X-rays. D0120 - Periodic oral evaluation D0140 - Limited oral evaluation - problem focused D9995 - Teledentistry - synchronous - real time encounter D9996 - Teledentistry - asynchronous - information stored and forwarded to dentist for subsequent review D0150 - Comprehensive oral evaluation - new or established patient D0180 - Comprehensive periodontal evaluation - new or established patient The following service is not subject to a frequency limit. D0160 - Detailed and extensive oral evaluation - problem focused, by report	
Intraoral Radiographs (X-ray) Limited to 2 series of films per 12 months. D0210 - Intraoral complete series of radiographic images D0709 - Intraoral - complete series of radiographic images - image capture only	50%
The following services are not subject to a frequency limit. D0220 - Intraoral - periapical first radiographic image D0230 - Intraoral - periapical - each additional radiographic image D0240 - Intraoral - occlusal radiographic image D0706 - Intraoral - occlusal radiographic image - image capture only D0707 - Intraoral - periapical radiographic image - image capture only	50%
Any combination of the following services is limited to 2 series of films per 12 months. D0270 - Bitewing - single radiographic image D0272 - Bitewings - two radiographic images D0274 - Bitewings - four radiographic images D0277 - Vertical bitewings - 7 to 8 radiographic images D0708 - Intraoral - bitewing radiographic image - image capture only	50%
Limited to 1 time per 36 months. D0330 - Panoramic radiograph image D0701 - Panoramic radiographic image - image capture only. D0702 - 2-D Cephalometric radiographic image - image capture only D0704 - 3-D Photographic image - image capture only	50%
The following service is limited to 2 images per 12 months. D0705 - Extra-oral posterior dental radiographic image - image capture only	50%
The following services are not subject to a frequency limit. D0340 - 2-D Cephalometric radiographic image - acquisition, measurement and analysis D0350 – 2-D Oral/Facial photographic images obtained intra-orally or extra-orally D0470 - Diagnostic casts	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D0703 - 2-D Oral/facial photographic image obtained intra-orally or extra-orally - image capture only	
Preventive Services - (Subject to payment of the Dental Services Deductible.)	
Dental Prophylaxis (Cleanings) The following services are limited to 2 times every 12 months. D1110 - Prophylaxis - adult D1120 - Prophylaxis - child	50%
Fluoride Treatments The following services are limited to 2 times every 12 months. D1206 - Topical application of fluoride varnish D1208 – Topical application of fluoride - excluding varnish	50%
Sealants (Protective Coating) The following services are limited to once per first or second permanent molar every 36 months. D1351 - Sealant - per tooth D1352 - Preventive resin restorations in moderate to high caries risk patient - permanent tooth	50%
Space Maintainers (Spacers) The following services are not subject to a frequency limit. D1510 - Space maintainer - fixed - unilateral - per quadrant D1516 - Space maintainer - fixed – bilateral maxillary D1517 - Space maintainer - fixed - bilateral mandibular D1520 - Space maintainer - removable - unilateral - per quadrant D1526 - Space maintainer - removable bilateral - bilateral maxillary D1527 - Space maintainer - removable - bilateral mandibular D1551 - Re-cement or re-bond bilateral space maintainer - maxillary D1552 - Re-cement or re-bond bilateral space maintainer - mandibular D1553 - Re-cement or re-bond unilateral space maintainer - per quadrant D1556 - Removal of fixed unilateral space maintainer - per quadrant D1557 - Removal of fixed bilateral space maintainer - maxillary D1558 - Removal of fixed bilateral space maintainer - mandibular D1575 - Distal shoe space maintainer - fixed - unilateral per quadrant	50%
Minor Restorative Services - (Subject to payment of the Dental Services Deductible.)	
Amalgam Restorations (Silver Fillings) The following services are not subject to a frequency limit. D2140 - Amalgams - one surface, primary or permanent D2150 - Amalgams - two surfaces, primary or permanent D2160 - Amalgams - three surfaces, primary or permanent D2161 - Amalgams - four or more surfaces, primary or permanent	50%
Composite Resin Restorations (Tooth Colored Fillings) The following services are not subject to a frequency limit.	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D2330 - Resin-based composite - one surface, anterior D2331 - Resin-based composite - two surfaces, anterior D2332 - Resin-based composite - three surfaces, anterior D2335 - Resin-based composite - four or more surfaces or involving incisal angle (anterior)	
Crowns/Inlays/Onlays - (Subject to payment of the Dental Services Deductible.)	
The following services are subject to a limit of 1 time every 60 months. D2542 - Onlay - metallic - two surfaces D2543 - Onlay - metallic - three surfaces D2544 - Onlay - metallic - four or more surfaces D2740 - Crown - porcelain/ceramic D2750 - Crown - porcelain fused to high noble metal D2751 - Crown - porcelain fused to predominately base metal D2752 - Crown - porcelain fused to noble metal D2753 - Crown - porcelain fused to titanium and titanium alloys D2780 - Crown - 3/4 cast high noble metal D2781 - Crown - 3/4 cast predominately base metal D2783 - Crown - 3/4 porcelain/ceramic D2790 - Crown - full cast high noble metal D2791 - Crown - full cast predominately base metal D2792 - Crown - full cast noble metal D2794 Crown – titanium and titanium alloys D2930 - Prefabricated stainless steel crown - primary tooth D2931 - Prefabricated stainless steel crown - permanent tooth The following services are not subject to a frequency limit. D2510 - Inlay - metallic - one surface D2520 - Inlay - metallic - two surfaces D2530 - Inlay - metallic - three surfaces D2910 - Re-cement or re-bond inlay D2920 - Re-cement or re-bond crown	50%
The following service is not subject to a frequency limit. D2940 - Protective restoration	50%
The following services are limited to 1 time per tooth every 60 months. D2929 - Prefabricated porcelain/ceramic crown - primary tooth D2950 - Core buildup, including any pins when required	50%
The following service is limited to 1 time per tooth every 60 months. D2951 - Pin retention - per tooth, in addition to restoration	50%
The following service is not subject to a frequency limit. D2954 - Prefabricated post and core in addition to crown	50%
The following services are not subject to a frequency limit. D2980 - Crown repair necessitated by restorative material failure D2981 - Inlay repair necessitated by restorative material failure D2982 - Onlay repair necessitated by restorative material failure	50%
Endodontics - (Subject to payment of the Dental Services Deductible.)	
The following service is not subject to a frequency limit. D3220 - Therapeutic pulpotomy (excluding final restoration)	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
The following service is not subject to a frequency limit. D3222 - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50%
The following services are not subject to a frequency limit. D3230 - Pulpal therapy (resorbable filling) - anterior - primary tooth (excluding final restoration) D3240 - Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	50%
The following services are not subject to a frequency limit. D3310 - Endodontic therapy anterior tooth (excluding final restoration) D3320 - Endodontic therapy premolar tooth (excluding final restoration) D3330 – Endodontic therapy molar tooth (excluding final restoration) D3346 - Retreatment of previous root canal therapy - anterior D3347 - Retreatment of previous root canal therapy - bicuspid D3348 - Retreatment of previous root canal therapy - molar	50%
The following services are not subject to a frequency limit. D3351 - Apexification/recalcification - initial visit D3352 - Apexification/recalcification/pulpal regeneration - interim medication replacement D3353 - Apexification/recalcification - final visit	50%
The following services are not subject to a frequency limit. D3410 - Apicoectomy - anterior D3421 - Apicoectomy - premolar (first root) D3425 - Apicoectomy - molar (first root) D3426 - Apicoectomy - (each additional root) D3471 - Surgical repair of root resorption - anterior D3472 - Surgical repair of root resorption - premolar D3473 - Surgical repair of root resorption - molar D3501 - Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior D3502 - Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar D3503 - Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	50%
The following services are not subject to a frequency limit. D3911 - Intraorifice barrier D3920 - Hemisection (including any root removal), not including root canal therapy	50%
Periodontics - (Subject to payment of the Dental Services Deductible.)	
The following services are limited to a frequency of 1 every 36 months. D4210 - Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant D4211 - Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	50%
The following services are limited to 1 every 36 months.	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D4240 - Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant D4241 - Gingival flap procedure, including root planing, one to three contiguous teeth or tooth bounded spaces per quadrant D4249 - Clinical crown lengthening - hard tissue	
The following services are limited to 1 every 36 months. D4260 - Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant D4261 - Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant D4263 - Bone replacement graft - retained natural tooth - first site in quadrant	50%
The following service is not subject to a frequency limit. D4270 - Pedicle soft tissue graft procedure	50%
The following services are not subject to a frequency limit. D4273 - Autogenous connective tissue graft procedure, per first tooth implant or edentulous tooth position in graft D4275 - Non-autogenous connective tissue graft first tooth implant D4277 - Free soft tissue graft procedure - first tooth D4278 - Free soft tissue graft procedure each additional contiguous tooth D4322 - Splint - intra-coronal, natural teeth or prosthetic crowns D4323 - Splint - extra-coronal, natural teeth or prosthetic crowns	50%
The following services are limited to 1 time per quadrant every 24 months. D4341 - Periodontal scaling and root planing - four or more teeth per quadrant D4342 - Periodontal scaling and root planing - one to three teeth per quadrant D4346 - Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	50%
The following service is subject to a limit of 1 time every 60 months. D4355 - Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit	50%
The following service is limited to 4 times every 12 months in combination with prophylaxis. D4910 - Periodontal maintenance	50%
Removable Dentures - (Subject to payment of the Dental Services Deductible.)	
The following services are limited to a frequency of 1 every 60 months. D5110 - Complete denture - maxillary D5120 - Complete denture - mandibular D5130 - Immediate denture - maxillary D5140 - Immediate denture - mandibular D5211 - Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5212 - Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D5213 - Maxillary partial denture - cast metal framework with resin denture base (including retentive/clasping materials, rests, and teeth) D5214 - Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) D5221 - Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5222 - Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth) D5223 - Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) D5224 - Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)D5227 - Immediate maxillary partial denture - flexible base (including any clasps, rests, and teeth) D5228 - Immediate mandibular partial denture - flexible base (including any clasps, rests, and teeth) D5282 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary D5283 - Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular D5284 - Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant D5286 - Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	
The following services are not subject to a frequency limit. D5410 - Adjust complete denture - maxillary D5411 - Adjust complete denture - mandibular D5421 - Adjust partial denture - maxillary D5422 - Adjust partial denture - mandibular D5511 - Repair broken complete denture base - mandibular D5512 - Repair broken complete denture base - maxillary D5520 - Replace missing or broken teeth - complete denture (each tooth) D5611 - Repair resin partial denture base - mandibular D5612 - Repair resin partial denture base - maxillary D5621 - Repair cast partial framework - mandibular D5622 - Repair cast partial framework - maxillary D5630 - Repair or replace broken retentive/clasping materials - per tooth D5640 - Replace broken teeth - per tooth D5650 - Add tooth to existing partial denture D5660 - Add clasp to existing partial denture	50%
The following services are limited to rebasing performed more than 6 months after the initial insertion with a frequency limitation of 1 time per 12 months. D5710 - Rebase complete maxillary dentureD5711 - Rebase complete mandibular denture D5720 - Rebase maxillary partial denture D5721 - Rebase mandibular partial denture D5725 - Rebase hybrid prosthesis D5730 - Reline complete maxillary denture (direct) D5731 - Reline complete mandibular denture (direct) D5740 - Reline maxillary partial denture (direct) D5741 - Reline mandibular partial denture (direct)	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D5750 - Reline complete maxillary denture (indirect) D5751 - Reline complete mandibular denture (indirect) D5760 - Reline maxillary partial denture (indirect) D5761 - Reline mandibular partial denture (indirect) D5876 - Add metal substructure to acrylic full denture (per arch)	
The following services are not subject to a frequency limit. D5765 - Soft liner for complete or partial removable denture - indirect D5850 - Tissue conditioning (maxillary) D5851 - Tissue conditioning (mandibular)	50%
Bridges (Fixed partial dentures) - (Subject to payment of the Dental Services Deductible.)	
The following services are not subject to a frequency limit. D6210 - Pontic - cast high noble metal D6211 - Pontic - cast predominately base metal D6212 - Pontic - cast noble metal D6214 - Pontic – titanium and titanium alloys D6240 - Pontic - porcelain fused to high noble metal D6241 - Pontic - porcelain fused to predominately base metal D6242 - Pontic - porcelain fused to noble metal D6243 - Pontic - porcelain fused to titanium and titanium alloys D6245 - Pontic - porcelain/ceramic	50%
The following services are not subject to a frequency limit. D6545 - Retainer - cast metal for resin bonded fixed prosthesis D6548 - Retainer - porcelain/ceramic for resin bonded fixed prosthesis	50%
The following services are limited to 1 time every 60 months. D6740 - Retainer crown - porcelain/ceramic D6750 - Retainer crown - porcelain fused to high noble metal D6751 - Retainer crown - porcelain fused to predominately base metal D6752 - Retainer crown - porcelain fused to noble metal D6753 - Retainer crown - porcelain fused to titanium and titanium alloys D6780 - Retainer crown - 3/4 cast high noble metal D6781 - Retainer crown - 3/4 cast predominately base metal D6782 - Retainer crown - 3/4 cast noble metal D6783 - Retainer crown - 3/4 porcelain/ceramic D6784 - Retainer crown - 3/4 titanium and titanium alloys D6790 - Retainer crown - full cast high noble metal D6791 - Retainer crown - full cast predominately base metal D6792 - Retainer crown - full cast noble metal	50%
The following service is not subject to a frequency limit. D6930 - Re-cement or re-bond FPD	50%
The following service is not subject to a frequency limit. D6980 - FPD repair necessitated by restorative material failure	50%
Oral Surgery - (Subject to payment of the Dental Services Deductible.)	
The following service is not subject to a frequency limit. D7140 - Extraction, erupted tooth or exposed root	50%
The following services are not subject to a frequency limit.	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D7210 - Surgical removal of erupted tooth requiring removal of bone sectioning of tooth, and including elevation of mucoperiosteal flap, if indicated D7220 - Removal of impacted tooth - soft tissue D7230 - Removal of impacted tooth - partially bony D7240 - Removal of impacted tooth - completely bony D7241 - Removal of impacted tooth - completely bony with unusual surgical complications D7250 - Surgical removal or residual tooth roots D7251 - Coronectomy - intentional partial tooth removal	
The following service is not subject to a frequency limit. D7270 - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50%
The following service is not subject to a frequency limit. D7280 - Surgical access exposure of an unerupted tooth	50%
The following services are not subject to a frequency limit. D7310 - Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7311 - Alveoloplasty in conjunction with extraction - one to three teeth or tooth spaces - per quadrant D7320 - Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant D7321 - Alveoloplasty not in conjunction with extractions - one to three teeth or tooth space - per quadrant	50%
The following service is not subject to a frequency limit. D7471 - Removal of lateral exostosis (maxilla or mandible)	50%
The following services are not subject to a frequency limit. D7510 - Incision and drainage of abscess, intraoral soft tissue D7910 - Suture of recent small wounds up to 5 cm D7953 - Bone replacement graft for ridge preservation - per site D7961 - Buccal/labial frenectomy (frenulectomy) D7962 - Lingual frenectomy (frenulectomy) D7971 - Excision of pericoronal gingiva	50%
Adjunctive Services - (Subject to payment of the Dental Services Deductible.)	
The following service is not subject to a frequency limit; however, it is covered as a separate benefit only if no other services (other than the exam and radiographs) were done on the same tooth during the visit. D9110 - Palliative (Emergency) treatment of dental pain - minor procedure	50%
Covered only when clinically Necessary. D9222 - Deep sedation/general anesthesia - first 15 minutesD9223 - Deep sedation/general anesthesia - each 15 minute increment D9239 - Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes D9610 - Therapeutic parenteral drug single administration	50%
Covered only when clinically Necessary	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D9310 - Consultation (diagnostic service provided by a dentist or Physician other than the practitioner providing treatment)	
The following is limited to 1 guard every 12 months. D9944 - Occlusal guard - hard appliance, full arch D9945 - Occlusal guard - soft appliance, full arch D9946 - Occlusal guard - hard appliance, partial arch	50%
Implant Procedures - (Subject to payment of the Dental Services Deductible.)	
The following services are limited to 1 time every 60 months. D6010 - Surgical placement of implant body: endosteal implant D6012 - Surgical placement of interim implant body D6040 - Surgical placement of eposteal implant D6050 – Surgical placement: transosteal implant D6055 - Connecting bar - implant supported or abutment supported D6056 - Prefabricated abutment - includes modification and placement D6057 - Custom fabricated abutment - includes placement D6058 - Abutment supported porcelain ceramic crown D6059 - Abutment supported porcelain fused to metal crown (high noble metal) D6060 - Abutment supported porcelain fused to metal crown (predominately base metal) D6061 - Abutment supported porcelain fused to metal crown (noble metal) D6062 - Abutment supported cast metal crown (high noble metal) D6063 - Abutment supported cast metal crown (predominately base metal) D6064 - Abutment supported cast metal crown (noble metal) D6065 - Implant supported porcelain/ceramic crown D6066 - Implant supported crown - porcelain fused to high noble alloys D6067 - Implant supported crown - high noble alloys D6068 - Abutment supported retainer for porcelain/ceramic FPD D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal) D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal) D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal) D6072 - Abutment supported retainer for cast metal FPD (high noble metal) D6073 - Abutment supported retainer for cast metal FPD (predominately base metal) D6074 - Abutment supported retainer for cast metal FPD (noble metal) D6075 - Implant supported retainer for ceramic FPD D6076 - Implant supported retainer for FPD - porcelain fused to high noble alloys D6077 - Implant supported retainer for metal FPD - high noble alloys D6080 - Implant maintenance procedure D6081 - Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure D6082 - Implant supported crown - porcelain fused to predominantly base alloys D6083 - Implant supported crown - porcelain fused to noble alloys D6084 - Implant supported crown - porcelain fused to titanium and titanium alloys D6086 - Implant supported crown - predominantly base alloys	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D6087 - Implant supported crown - noble alloys D6088 - Implant supported crown - titanium and titanium alloys D6090 - Repair implant supported prosthesis, by report D6091 - Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment D6095 - Repair implant abutment, by report D6096 - Remove broken implant retaining screw D6097 - Abutment supported crown - porcelain fused to titanium and titanium alloys D6098 - Implant supported retainer - porcelain fused to predominantly base alloys D6099 - Implant supported retainer for FPD - porcelain fused to noble alloys D6100 - Surgical removal of implant body D6101 - Debridement peri-implant defect D6102 - Debridement and osseous contouring of a peri-implant defect D6103 - Bone graft for repair of peri-implant defect D6104 - Bone graft at time of implant replacement D6118 - Implant/abutment supported interim fixed denture for edentulous arch - mandibular D6119 - Implant/abutment supported interim fixed denture for edentulous arch - maxillary D6120 - Implant supported retainer - porcelain fused to titanium and titanium alloys D6121 - Implant supported retainer for metal FPD - predominantly base alloys D6122 - Implant supported retainer for metal FPD - noble alloys D6123 - Implant supported retainer for metal FPD - titanium and titanium alloys D6190 – Radiographic/surgical implant index, by report D6191 - Semi-precision abutment - placement D6192 - Semi-precision attachment - placement D6195 - Abutment supported retainer - porcelain fused to titanium and titanium alloys	
Medically Necessary Orthodontics - (Subject to payment of the Dental Services Deductible.)	
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's Syndrome, Treacher-Collins Syndrome, Pierre-Robin Syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized. Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed. Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically Necessary.	
The following services are not subject to a frequency limitation as long as benefits have been prior authorized. D8010 - Limited orthodontic treatment of the primary dentition D8020 - Limited orthodontic treatment of the transitional dentition	50%

Amounts shown below in the Schedule of Benefits are based on Allowed Dental Amounts	
What Are the Procedure Codes, Benefit Description and Frequency Limitations?	**Benefits**
D8030 - Limited orthodontic treatment of the adolescent dentition D8070 - Comprehensive orthodontic treatment of the transitional dentition D8080 - Comprehensive orthodontic treatment of the adolescent dentition D8210 - Removable appliance therapy D8220 - Fixed appliance therapy D8660 - Pre-orthodontic treatment visit D8670 - Periodic orthodontic treatment visit D8680 - Orthodontic retention D8695 - Removal of fixed orthodontic appliances for reasons other than completion of treatment D8696 - Repair of orthodontic appliance - maxillary D8697 - Repair of orthodontic appliance - mandibular D8698 - Re-cement or re-bond fixed retainer - maxillary D8699 - Re-cement or re-bond fixed retainer - mandibular D8701 - Repair of fixed retainer, includes reattachment - maxillary D8702 - Repair of fixed retainer, includes reattachment - mandibular	

Section 3: Pediatric Dental Exclusions

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

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven Service in the treatment of that particular condition.
8. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. See the Covered Medical Expense Benefits section of the Certificate for covered services.
9. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision. See the Covered Medical Expense Benefits section of the Certificate for covered services.
10. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
11. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint. See the Covered Medical Expense Benefits section of the Certificate for covered services.
12. Charges for not keeping a scheduled appointment without giving the dental office 24 hours notice.
13. Expenses for Dental Procedures begun prior to the Insured Person becoming enrolled for coverage provided through the Policy.

14. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.
15. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the Policy.

Section 4: Claims for Pediatric Dental Services

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

Reimbursement for Dental Services

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

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

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage, The Insured Person must include the name of the other carrier(s).

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

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
Claims Fax# 806-473-3136

If the Insured Person would like to use a claim form, call Customer Service at 1-844-206-0374. If the Insured Person does not receive the claim form within 15 calendar days of the request, the proof of loss may be submitted with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

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

Allowed Dental Amounts - Allowed Dental Amounts for Covered Dental Services, incurred while the Policy is in effect. When Covered Dental Services are received from Dental Providers, Allowed Dental Amounts are the Usual and Customary Fees, as defined below.

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

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

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

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

Dental Services Deductible - the amount the Insured Person must pay for Covered Dental Services in a Policy Year before the Company will begin paying for benefits in that Policy Year.

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

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

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

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

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

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

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

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

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

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

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.

- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

Section 19: Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Vision Care Provider.

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

Benefits for Vision Care Services are determined as a percentage of the provider's billed charge.

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

Policy Deductible

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

What Are the Benefit Descriptions?

Benefits

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

Frequency of Service Limits

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

Routine Vision Examination

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

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

- Diagnosis/prognosis.
- Specific recommendations.

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

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

Eyeglass Lenses

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

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

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

Eyeglass Frames

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

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

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

Contact Lenses

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

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

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

Necessary Contact Lenses

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

Contact lenses are necessary if the Insured Person has any of the following:
- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision

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

Benefits include:

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

Schedule of Benefits

Benefit percentages shown below are the percentages of covered Vision Care Services that the Company pays.

Vision Care Service	What is the Frequency of Service?	Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per policy year.	50% of the billed charge.
Eyeglass Lenses	Once per policy year.	
• Single Vision		50% of the billed charge.
• Bifocal		50% of the billed charge.
• Trifocal		50% of the billed charge.
• Lenticular		50% of the billed charge.
Lens Extras	Once per policy year.	
• Polycarbonate lenses		100% of the billed charge.
• Standard scratch-resistant coating		100% of the billed charge.
• Each of the following is a separate charge shown under columns Network and Non-Network Benefits: ▪ Blended segment lenses, ▪ Intermediate vision lenses. ▪ Standard Progressives. ▪ Premium Progressives ▪ Photochromic Glass ▪ Plastic Photosensitive ▪ Polarized ▪ Hi-Index ▪ Standard Anti-Reflective Coating		40% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Benefit
▪ Premium Anti-Reflective Coating ▪ Ultra Anti-Reflective Coating • UV Coating		
• Tint		40% of the billed charge.
• Oversized lenses		40% of the billed charge.
Vision Care Service	**What is the Frequency of Service?**	**Benefit**
Eyeglass Frames	Once per policy year.	
• Eyeglass frames with a retail cost up to $130.		50% of the billed charge.
• Eyeglass frames with a retail cost of $130 - 160.		50% of the billed charge.
• Eyeglass frames with a retail cost of $160 - 200.		50% of the billed charge.
• Eyeglass frames with a retail cost of $200 - 250.		50% of the billed charge.
• Eyeglass frames with a retail cost greater than $250.		50% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Benefit
Contact Lenses Fitting & Evaluation	Once per policy year.	100%
Contact Lenses		
• Contact Lens	Limited to a 12 month supply.	50% of the billed charge.
• Necessary Contact Lenses	Limited to a 12 month supply.	50% of the billed charge.

Vision Care Service	What is the Frequency of Service?	Benefit
Low Vision Care Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Care Services, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.	
• Low vision testing		75% of the billed charge.

• Low vision therapy		75% of the billed charge.

Section 2: Pediatric Vision Exclusions

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

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

Section 3: Claims for Pediatric Vision Care Services

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

Reimbursement for Vision Care Services

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

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

Submit the above information to the Company:

By mail:

HealthSmart Benefit Solutions, Inc.
3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
1-844-206-0374
Claims Fax #: 806-473-3136

Section 4: Defined Terms for Pediatric Vision Care Services

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

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

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

Section 20: HealthSmart Rx Prescription Drug Expense Benefit

Network Prescription Drug Expense Benefit
The Prescription Drug Program is available through HealthSmart Rx.

After the insured pays 10% for each 31-day supply for generic drug, 20% for each 31-day supply for a brand name drug or 50% for each 31-day supply for brand name with a generic equivalent drug or the Expenses incurred for the balance of prescription drugs will be reimbursed at 100%. Minimum cost to the insured is $10 or the cost of the drug, whichever is less. Prescriptions must be filled at a participating pharmacy with HealthSmart Rx Pharmacy. Insured Persons will use their student health insurance ID card to show the pharmacy proof of coverage. If a Prescription needs to be filled prior to receiving an ID card, reimbursement will be made for a covered prescription upon a completed and submitted Prescription Drug claim form.

Expenses incurred for the following are excluded under the Plan: fertility medications; legend vitamins or food supplements; except as provided in the policy; immunization agents and vaccines, except as provided in the policy; biological sera; blood plasma; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed at a Hospital or rest home. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: (a) the American Medical Association Drug Evaluations; (b) the American Hospital Formulary Service Drug Information; (c) the United States Pharmacopoeia Drug Information; or (d) it is recommended by a clinical study or review article in a major peer-reviewed professional journal. However, Covered Medical Expenses do not include experimental or investigational drugs, or any drug, which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

To locate a participating pharmacy, call HealthSmart Rx Pharmacy at 1-800-681-6912 or create an account at:

www.healthsmart.com and click on "STUDENT."

When prescriptions are filled at pharmacies outside the HealthSmart RX network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to HealthSmart Rx, Inc., 3320 West Market St., Fairlawn, OH 44333.

See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

Schedule of Benefits

THE OHIO STATE UNIVERSITY - DOMESTIC STUDENT PLAN
2023-1098-1
METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 90.280%
Injury and Sickness Benefits

This Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums, and other limits that apply when the Insured Person obtains Covered Medical Expenses for a covered Injury or Sickness. Please refer to the Medical Expense Benefits section of the Certificate for a more complete explanation of the benefits provided under the Policy.

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

Deductible Select Provider	$150 (Per Insured Person, Per Policy Year)
Deductible Select Provider	$350 (For all Insureds in a Family, Per Policy Year)
Deductible Preferred Provider	$500 (Per Insured Person, Per Policy Year)
Deductible Preferred Provider	$1,500 (For all Insureds in a Family, Per Policy Year)
Deductible Out-of-Network Provider	$500 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network Provider	$1,500 (For all Insureds in a Family, Per Policy Year)
Coinsurance Select Provider	90% of Allowed Amount, except as noted below
Coinsurance Preferred Provider	60% of Allowed Amount, except as noted below
Coinsurance Out-of-Network Provider	60% of Allowed Amount, except as noted below
Out-of-Pocket Maximum Select Provider	$3,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Select Provider	$6,000 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$6,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	$12,000 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$6,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network Provider	$12,000 (For all Insureds in a Family, Per Policy Year)

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

The **Select Providers** for this plan are OSU Health Plan Network in Franklin County and UnitedHealthcare Options PPO outside Franklin County. The **Preferred Providers** for this plan are UnitedHealthcare Options PPO providers inside Franklin County.

Select Provider Benefits apply to Covered Medical Expenses that are provided by a Select Provider. If care is received from a Select Provider (OSU Health Plan Network in Franklin County and UnitedHealthcare Options PPO outside Franklin County), any Covered Medical Expenses will be paid at the Select Provider Benefit level.

Preferred Provider Benefits apply to Covered Medical Expenses that are provided by a Preferred Provider. If care is received from a Preferred Provider (UnitedHealthcare Options PPO inside Franklin County), any Covered Medical Expenses will be paid at the Preferred Provider Benefit level.

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

When treatment is rendered outside the United States, Covered Medical Expenses will be paid at the Select Provider (Tier 2) level of benefits.

The Policy provides patient protections from Out-of-Network Provider surprise bills ("balance billing") for Emergency Services and other specified items or services. The Company complies with these patient protections as established under Ohio Revised Code Sections 3902.50 through 3902.54, Ohio Administrative Code Section 3901-8-17, and the Federal No Surprises Act.

Out-of-Pocket Maximum: The Per Insured Person Out-of-Pocket Maximum applies to each person covered under the Policy each Policy Year. After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at

100% for the remainder of the Policy Year for that person. However, after the Out-of-Pocket Maximum for Insured Persons in a family collectively totals the For all Insureds in a Family Out-of-Pocket Maximum in a Policy Year, Covered Medical Expenses will be paid at 100% for any insured family member for the remainder of the Policy Year. Covered Medical Expenses used to satisfy any of the Out-of-Pocket Maximums will be applied to the Select Provider, Preferred Provider and Out-of-Network Provider Out-of-Pocket Maximums. Services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum.

Any amount the Insured Person pays in Coinsurance, Copayments, Deductibles, or reductions for failing to comply with Policy provisions or requirements for covered Pediatric Dental Services or covered Pediatric Vision Services applies to the Out-of-Pocket Maximum.

Family Out-of-Pocket Maximum: Once an Insured Person in a family meets their Per Insured Person, Per Policy Year Out-of-Pocket Maximum, Covered Medical Expenses for that Insured Person will be paid at 100% and no further Out-of-Pocket Maximum is required for that Insured Person. Other covered family members must continue to meet their Per Insured Person, Per Policy Year Out-of-Pocket Maximum until the overall family Policy Year Out-of-Pocket Maximum has been met. Once the overall family Policy Year Out-of-Pocket Maximum amount has been met, no further Out-of-Pocket Maximum amount will be required for any family member covered under the Policy for the remainder of the Policy Year.

Family Deductible: Once an Insured Person in a family meets their Per Insured Person, Per Policy Year Deductible, no further Deductible is required for that Insured Person. Other covered family members must continue to meet their Per Insured Person, per Policy Year Deductible until the overall family Policy Year Deductible amount has been met. Once the overall family Policy Year Deductible amount has been met, no further Deductible amount will be required for any family member covered under the Policy for the remainder of the Policy Year.

Covered Medical Expenses used to satisfy the Preferred Provider Deductibles will be applied to the Out-of-Network Provider Deductibles, and Covered Medical Expenses used to satisfy the Out-of-Network Provider Deductibles will be applied to the Preferred Provider Deductibles. The Select Provider Deductibles do not apply to the Preferred Provider and/or Out-of-Network Provider Deductibles.

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

Inpatient	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
Room and Board Expense	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Intensive Care	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Miscellaneous Expenses	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Routine Newborn Care	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Inpatient	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.			
Anesthetist Services	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Registered Nurse's Services	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Pre-admission Testing Payable within 7 working days prior to admission**.**	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Outpatient	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Day Surgery Miscellaneous	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Assistant Surgeon Fees If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Anesthetist Services	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physician's Visits	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Physiotherapy Limits per Policy Year as follows: 20 visits of physical therapy 20 visits of occupational therapy 20 visits of speech therapy 12 visits of manipulative therapy	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Outpatient	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
Separate physical, occupational, and speech therapy limits apply to rehabilitative and Habilitative Services.			
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	$100 Copay per visit 90% of Allowed Amount not subject to Deductible	$100 Copay per visit 90% of Allowed Amount not subject to Deductible	$100 Copay per visit 90% of the Allowed Amount not subject to Deductible
Diagnostic X-ray Services	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Radiation Therapy	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Laboratory Procedures	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Tests & Procedures	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Injections	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Chemotherapy	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Prescription Drugs Minimum cost to the Insured Person is $10 or the cost of the drug, whichever is less. Prescription Drugs covered under the Preventive Care Services benefit will be paid at the benefit levels shown under Preventive Care Services. (Birth Control benefit determination, please review the public document at www.unitedhealthcareonline.com)	HealthSmart Rx 90% Coinsurance per prescription generic drug 80% Coinsurance per prescription brand-name drug 50% Coinsurance per prescription non-formulary up to a 31-day supply per prescription not subject to Deductible	HealthSmart Rx 90% Coinsurance per prescription generic drug 80% Coinsurance per prescription brand-name drug 50% Coinsurance per prescription non-formulary up to a 31-day supply per prescription not subject to Deductible	Non-network Pharmacy 90% Coinsurance per prescription generic drug 50% Coinsurance per prescription brand-name drug 50% Coinsurance per prescription non-formulary Up to a 31-day supply per prescription not subject to Deductible

Other	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
Ambulance Services	90% of Allowed Amount after Deductible	90% of Allowed Amount after Deductible	90% of Allowed Amount after Deductible
Durable Medical Equipment	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Consultant Physician Fees	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only or as specifically described in the Policy.	90% of Allowed Amount after Deductible	90% of Allowed Amount after Deductible	90% of Allowed Amount after Deductible

Other	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
Mental Illness Treatment See also Benefits for Biologically Based Mental Illness (See Select Provider and Preferred Provider section in Section 6 on page 5 for information on covered Select Provider and Preferred Provider Inpatient facilities.)	**Inpatient:** 90% of Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 90% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Allowed Amount after Deductible
Substance Use Disorder Treatment (See Select Provider and Preferred Provider section in Section 6 on page 5 for information on covered Select Provider and Preferred Provider Inpatient facilities.)	**Inpatient:** 90% of Allowed Amount after Deductible **Outpatient office visits:** $20 Copay per visit 100% of Allowed Amount not subject to Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 90% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Allowed Amount after Deductible	**Inpatient:** 60% of Allowed Amount after Deductible **Outpatient office visits:** 60% of Allowed Amount after Deductible **All other outpatient services, except Medical Emergency Expenses and Prescription Drugs:** 60% of Allowed Amount after Deductible
Maternity See also Benefits for Maternity Follow-Up Care	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Complications of Pregnancy	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider or In-Network Provider. Information regarding preventive services may be obtained from Customer Service at 1-844-206-0374 and at the following websites: http://www.uspreventiveservicestaskforce.org and http://www.hrsa.gov/womensguidelines/	100% of Allowed Amount	100% of Allowed Amount	60% of Allowed Amount after Deductible
Reconstructive Breast Surgery Following Mastectomy	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Diabetes Services	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed

Other	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
Home Health Care 100 visits maximum per Policy Year / Additional 250 visit maximum per Policy Year for Private Duty Nursing	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospice Care	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Inpatient Rehabilitation Facility	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Skilled Nursing Facility	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Urgent Care Center	$25 Copay per visit 100% of Allowed Amount not subject to Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Hospital Outpatient Facility or Clinic	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Approved Clinical Trials See also Benefits for Cancer Clinical Trials	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Transplantation Services	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Reconstructive Procedures	Based on setting where service is performed	Based on Setting where service is performed	Based on setting where service is performed
Allergy Testing and Treatment	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Gender Dysphoria Treatment	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Male Sterilization	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Medical Supplies Benefits are limited to a 31-day supply per purchase.	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Ostomy Supplies	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Temporomandibular Joint Disorder	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Vision Correction	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed
Wigs	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Non-EHB benefits added to plan			
Acupuncture 10 visits maximum – only certain diagnostic codes covered.	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Elective Abortion Graduate Associates or Fellows receiving a premium subsidy from The Ohio State University are not eligible for this benefit.	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible
Non-Prescription Enteral Formula	90% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible	60% of Allowed Amount after Deductible

Other	Select Provider Benefits (Tier 2)	Preferred Provider Benefits (Tier 3)	Out-of-Network Provider Benefits (Tier 4)
Routine Eye Exam $50 maximum per Policy Year, except as provided for in Pediatric Vision Benefits.	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	$20 Copay per visit 100% of Allowed Amount not subject to Deductible	$20 Copay per visit 100% of Allowed Amount not subject to Deductible
Human Organ Transplant – Donor Search $30,000 maximum, except as provided for in Transplantation Services.	Based on setting where service is performed	Based on setting where service is performed	Based on setting where service is performed

UNITEDHEALTHCARE INSURANCE COMPANY

POLICY ENDORSEMENT

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

President

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

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

Domestic Students are eligible for Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program. The Domestic Student's insured spouse, Domestic Partner (if listed as a "Class of Person" to be insured in the Policyholder Application), and insured minor child(ren) are also eligible to receive Assistance and Evacuation Benefits when 100 miles or more away from their campus address or 100 miles or more away from their permanent home address or while participating in a study abroad program.

Assistance and Evacuation Benefits

DEFINITIONS

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

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

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

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

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

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

MEDICAL EVACUATION AND REPATRIATION BENEFITS

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

Dispatch of Doctors/Specialists: If an Insured Person experiences an Emergency Medical Event and the Company's affiliate or authorized vendor determines that an Insured Person cannot be adequately assessed by telephone for possible medical evacuation from the initial medical facility or that the Insured Person cannot be moved and local treatment is unavailable, the Company's affiliate or authorized vendor will arrange to send an appropriate medical practitioner to the Insured Person's location when it deems it appropriate for medical management of a case. The Company will pay costs for transportation and expenses associated with dispatching a medical practitioner to an Insured Person's location, not including the costs of the medical practitioner's service.

Medical Repatriation: After an Insured Person receives initial treatment and stabilization for a Sickness or Injury, if the attending physician and the Medical Director of the Company's affiliate or authorized vendor determine that it is medically necessary, the Company's affiliate or authorized vendor will transport an Insured Person back to the Insured Person's permanent place of residence for further medical treatment or to recover. The Company will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Transportation after Stabilization: If Medical Repatriation is not required following stabilization of the Insured Person's condition and discharge from the hospital, the Company's affiliate or authorized vendor will coordinate transportation to the Insured Person's point of origin, Home Country, or Host Country. The Company will pay costs for economy transportation (or upgraded transportation to match an Insured Person's originally booked travel arrangements) to the Insured Person's original point of origin, Home Country or Host Country.

Transportation to Join a Hospitalized Insured Person: If an Insured Person who is travelling alone is or will be hospitalized for more than three (3) days due to a Sickness or Injury, the Company's affiliate or authorized vendor will coordinate round-trip airfare for a person of the Insured Person's choice to join the Insured Person. The Company will pay costs for economy class round-trip airfare for a person to join the Insured Person.

Return of Minor Children: If an Insured Person's minor child(ren) age 18 or under are present but left unattended as a result of the Insured Person's Injury or Sickness, the Company's affiliate or authorized vendor will coordinate airfare to send them back to the Insured Person's Home Country. The Company's affiliate or authorized vendor will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required as determined by the Company's affiliate or authorized vendor. The Company will pay costs for economy class one-way airfare for the minor children (or upgraded transportation to match the Insured Person's originally booked travel arrangement) and, if required, the cost of the services, transportation expenses, and accommodations of a non-medical escort to accompany the minor children back to the Insured Person's Home Country.

Repatriation of Mortal Remains: In the event of an Insured Person's death, the Company's affiliate or authorized vendor will assist in obtaining the necessary clearances for the Insured Person's cremation or the return of the Insured Person's mortal remains. The Company's affiliate or authorized vendor will coordinate the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. The Company will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Insured Person's mortal remains to the Insured Person's Home Country or place of primary residence.

CONDITIONS AND LIMITATIONS

Assistance and Evacuation Benefits shall only be provided to an Insured Person after the Company's affiliate or authorized vendor receives the request (in writing or via phone) from the Insured Person or an authorized representative of the Insured Person of the need for the requested Assistance and Evacuation Benefits. In all cases, the requested Assistance and Evacuation Benefits services and payments must be arranged, authorized, verified and approved in advance by the Company's affiliate or authorized vendor.

With respect to any evacuation requested by an Insured Person, the Company's affiliate or authorized vendor reserves the right to determine, at its sole discretion, the need for and the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician Advisors and treating physicians as needed to make its determination.

In the event an Insured Person is incapacitated or deceased, his/her designated or legal representative shall have the right to act for and on behalf of the Insured Person.

The following Exclusions and Limitations apply to the Assistance and Evacuation Benefits.

In no event shall the Company be responsible for providing Assistance and Evacuation Benefits to an Insured Person in a situation arising from or in connection with any of the following:

1. Travel costs that were neither arranged nor approved in advance by the Company's affiliate or authorized vendor.
2. Taking part in military or police service operations.
3. Insured Person's failure to properly procure or maintain immigration, work, residence or similar type visas, permits or documents.
4. The actual or threatened use or release of any nuclear, chemical or biological weapon or device, or exposure to nuclear reaction or radiation, regardless of contributory cause.
5. Any evacuation or repatriation that requires an Insured Person to be transported in a biohazard-isolation unit.
6. Medical Evacuations from a marine vessel, ship, or watercraft of any kind.
7. Medical Evacuations directly or indirectly related to a natural disaster.
8. Subsequent Medical Evacuations for the same or related Sickness, Injury or Emergency Medical Event regardless of location.

Additional Assistance Services

The following assistance services will be available to an Insured Person in addition to the Assistance and Evacuation Benefits.

MEDICAL ASSISTANCE SERVICES

Worldwide Medical and Dental Referrals: Upon an Insured Person's request, the Company's affiliate or authorized vendor will provide referrals to physicians, hospitals, dentists, and dental clinics in the area the Insured Person is traveling in order to assist the Insured Person in locating appropriate treatment and quality care.

Monitoring of Treatment: As and to the extent permissible, the Company's affiliate or authorized vendor will continually monitor the Insured Person's medical condition. Third-party medical providers may offer consultative and advisory services to the Company's affiliate or authorized vendor in relation to the Insured Person's medical condition, including review and analysis of the quality of medical care received by the Insured Person.

Facilitation of Hospital Admittance Payments: The Company's affiliate or authorized vendor will issue a financial guarantee (or wire funds) on behalf of Company up to five thousand dollars (US$5,000) to facilitate admittance to a foreign (non-US) medical facility.

Relay of Insurance and Medical Information: Upon an Insured Person's request and authorization, the Company's affiliate or authorized vendor will relay the Insured Person's insurance benefit information and/or medical records and information to a health care provider or treating physician, as appropriate and permissible, to help prevent delays or denials of medical care. The Company's affiliate or authorized vendor will also assist with hospital admission and discharge planning.

Medication and Vaccine Transfers: In the event a medication or vaccine is not available locally, or a prescription medication is lost or stolen, the Company's affiliate or authorized vendor will coordinate the transfer of the medication or vaccine to Insured Persons upon the prescribing physician's authorization, if it is legally permissible.

Updates to Family, Employer, and Home Physician: Upon an Insured Person's approval, the Company's affiliate or authorized vendor will provide periodic case updates to appropriate individuals designated by the Insured Person in order to keep them informed.

Hotel Arrangements: The Company's affiliate or authorized vendor will assist Insured Persons with the arrangement of hotel stays and room requirements before or after hospitalization or for ongoing care.

Replacement of Corrective Lenses and Medical Devices: The Company's affiliate or authorized vendor will assist with the replacement of corrective lenses or medical devices if they are lost, stolen, or broken during travel.

WORLDWIDE DESTINATION INTELLIGENCE

Destination Profiles: When preparing for travel, an Insured Person can contact the Company's affiliate or authorized vendor to have a pre-trip destination report sent to the Insured Person. This report draws upon an intelligence database of over 280 cities covering subject such as health and security risks, immunizations, vaccinations, local hospitals, crime,

emergency phone numbers, culture, weather, transportation information, entry and exit requirements, and currency. The global medical and security database of over 170 countries and 280 cities is continuously updated and includes intelligence from thousands of worldwide sources.

TRAVEL ASSISTANCE SERVICES

Replacement of Lost or Stolen Travel Documents: The Company's affiliate or authorized vendor will assist the Insured Person in taking the necessary steps to replace passports, tickets, and other important travel documents.

Emergency Travel Arrangements: The Company's affiliate or authorized vendor will make new reservations for airlines, hotels, and other travel services for an Insured Person in the event of a Sickness or Injury, to the extent that the Insured Person is entitled to receive Assistance and Evacuation Benefits.

Transfer of Funds: The Company's affiliate or authorized vendor will provide the Insured Person with an emergency cash advance subject to the Company's affiliate or authorized vendor first securing funds from the Insured Person (via a credit card) or his/her family.

Legal Referrals: Should an Insured Person require legal assistance, the Company's affiliate or authorized vendor will direct the Insured Person to a duly licensed attorney in or around the area where the Insured Person is located.

Language Services: The Company's affiliate or authorized vendor will provide immediate interpretation assistance to an Insured Person in a variety of languages in an emergency situation. If a requested interpretation is not available or the requested assistance is related to a non-emergency situation, the Company's affiliate or authorized vendor will provide the Insured Person with referrals to interpreter services. Written translations and other custom requests, including an on-site interpreter, will be subject to an additional fee.

Message Transmittals: Insured Persons may send and receive emergency messages toll-free, 24-hours a day, through the Company's affiliate or authorized vendor.

HOW TO ACCESS ASSISTANCE AND EVACUATION SERVICES

Assistance and Evacuation Services are available 24 hours a day, 7 days a week, 365 days a year.

To access services, please refer to the phone number on the back of the Insured Person's ID Card or access My Account at www.uhcsr.com/MyAccount and select My Benefits/Additional Benefits/UHC Global Emergency Services.

When calling the Emergency Response Center, the caller should be prepared to provide the following information:

- Caller's name, telephone and (if possible) fax number, and relationship to the Insured Person.
- Insured Person's name, age, sex, and ID Number as listed on the Insured Person's Medical ID card.
- Description of the Insured Person's condition.
- Name, location, and telephone number of hospital, if applicable.
- Name and telephone number of the attending physician.
- Information on where the physician can be immediately reached.

If the condition is a medical emergency, the Insured Person should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

All medical expenses related to hospitalization and treatment costs incurred should be submitted to the Company for consideration at the address located in the "How to File a Claim for Injury and Sickness Benefits" section of the Certificate of Coverage and are subject to all Policy benefits, provisions, limitations, and exclusions.

NON-DISCRIMINATION NOTICE

UnitedHealthcare Student Resources does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
United HealthCare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the written complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.

If you need help with your complaint, please call the toll-free member phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m. ET.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

LANGUAGE ASSISTANCE PROGRAM

We provide free services to help you communicate with us, such as, letters in other languages or large print. Or, you can ask for free language services such as speaking with an interpreter. To ask for help, please call toll-free 1-866-260-2723, Monday through Friday, 8 a.m. to 8 p.m. ET.

English
Language assistance services are available to you free of charge. Please call 1-866-260-2723.

Albanian
Shërbimet e ndihmës në gjuhën amtare ofrohen falas. Ju lutemi telefononi në numrin 1-866-260-2723.

Amharic
የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። እባክዎ ወደ 1-866-260-2723 ይደውሉ።

Arabic
تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم 1-866-260-2723.

Armenian
Ձեզ մատչելի են անվճար լեզվական օգնության ծառայություններ: Խնդրում ենք զանգահարել 1-866-260-2723 համարով:

Bantu- Kirundi
Uronswa ku buntu serivisi zifatiye ku rurimi zo kugufasha. Utegerezwa guhamagara 1-866-260-2723.

Bisayan- Visayan (Cebuano)
Magamit nimo ang mga serbisyo sa tabang sa lengguwahe nga walay bayad. Palihug tawag sa 1-866-260-2723.

Bengali- Bangala
ঘোষণা : ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। দয়া করে 1-866-260-2723-তে কল করুন।

Burmese
ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ သင့် အတွက် အခမဲ့ရရှိနိုင်သည်။ ကျေးဇူးပြု၍ ဖုန်း 1-866-260-2723 ကိုခေါ်ပါ။

Cambodian- Mon-Khmer
សេវាជំនួយផ្នែកភាសាដែលឥតគិតថ្លៃ មានសម្រាប់អ្នក។ សូមទូរស័ព្ទទៅលេខ 1-866-260-2723។

Cherokee
ᎧᏃᎮᏍᎩ ᎤᎾᏓᏡᎬᎢ ᎤᎾᏓᏡᏍᎬᎢ ᏂᎦ ᎡᎶᎯ ᏂᏓᏅᎯ ᎠᏂᏆᎳᏏ ᏂᎨᏍᏗ ᏂᏓ ᏕᎦᏅᏅᎩ 1-866-260-2723.

Chinese
您可以免費獲得語言援助服務。請致電 1-866-260-2723。

Choctaw
Chahta anumpa ish anumpuli hokmvt tohsholi yvt peh pilla h<u>o</u> chi apela hinla. I paya 1-866-260-2723.

Cushite- Oromo
Tajaajilliwwan gargaarsa afaanii kanfalttii malee siif jira. Maaloo karaa lakkoofsa bilbilaa 1-866-260-2723 bilbili.

Dutch
Taalbijstandsdiensten zijn gratis voor u beschikbaar. Gelieve 1-866-260-2723 op te bellen.

French
Des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-260-2723.

French Creole- Haitian Creole
Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-260-2723.

German
Sprachliche Hilfsdienstleistungen stehen Ihnen kostenlos zur Verfügung. Bitte rufen Sie an unter: 1-866-260-2723.

Greek
Οι υπηρεσίες γλωσσικής βοήθειας σας διατίθενται δωρεάν. Καλέστε το 1-866-260-2723.

Gujarati
ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. કૃપા કરીને 1-866-260-2723 પર કૉલ કરો.

Hawaiian
Kōkua manuahi ma kāu ʻōlelo i loaʻa ʻia. E kelepona i ka helu 1-866-260-2723.

Hindi
आप के लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपया 1-866-260-2723 पर कॉल करें।

Hmong
Muaj cov kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-260-2723.

Ibo
Enyemaka na-ahazi asụsụ, bu n'efu, dịrị gị. Kpọọ 1-866-260-2723.

Ilocano
Adda awan bayadna a serbisio para iti language assistance. Pangngaasim ta tawagam ti 1-866-260-2723.

Indonesian
Layanan bantuan bahasa bebas biaya tersedia untuk Anda. Harap hubungi 1-866-260-2723.

Italian
Sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-260-2723.

Japanese
無料の言語支援サービスをご利用いただけます。1-866-260-2723 までお電話ください。

Karen
ကျိာ်တၢ်မၤစၢၤအဂီၢ်နမၤန့ၢ်အီၤသ့ဝဲလၢတလိာ်ဟ့ဉ်အပှ့ၤဘဉ်(ခီလီ)န့ဉ်လီၤ. ဝံသးစူၤဆဲးကျိးဘဉ် 1-866-260-2723တက့ၢ်.

Korean
언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-260-2723 번으로 전화하십시오.

Kru- Bassa
Bot ba hola ni kobol mahop ngui nsaa wogui wo ba yé ha i nyuu yoŋ. Sebel i nsinga ini 1-866-260-2723.

Kurdish Sorani
خزمەتگکانی یارمەتیی زمانی بەخۆڕایی بۆ تۆ دابین دەکرێن. تکایە تەلەفۆن بکە بۆ ژمارەی 1-866-260-2723.

Laotian
ມີບໍລິການທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ກະລຸນາໂທຫາເບີ 1-866-260-2723.

Marathi
भाषेच्या मदतीची सुविधा आपल्याला विनामूल्य उपलब्ध आहे. त्यासाठी 1-866-260-2723 या क्रमांकावर संपर्क करा.

Marshallese
Kwomaroñ bōk jerbal in jipañ in kajin ilo ejjeļo̧k wōņāān. Jouj im kaļļo̧k 1-866-260-2723.

Micronesian- Pohnpeian
Mie sawas en mahsen ong komwi, soh isepe. Melau eker 1-866-260-2723.

Navajo
Saad bee áka'e'eyeed bee áka'nída'wo'ígíí t'áá jíík'eh bee nich'į' bee ná'ahoot'i'. T'áá shǫǫdí kohjį' 1-866-260-2723 hodíilnih.

Nepali
भाषा सहायता सेवाहरू निःशुल्क उपलब्ध छन्। कृपया 1-866-260-2723 मा कल गर्नुहोस्।

Nilotic-Dinka
Käk ë kuny ajuɛɛr ë thok atö tïnë yïn abac të cïn wëu yeke thiëëc. Yïn cɔl 1-866-260-2723.

Norwegian
Du kan få gratis språkhjelp. Ring 1-866-260-2723.

Pennsylvania Dutch
Schprooch iwwesetze Hilf kannscht du frei hawwe. Ruf 1-866-260-2723.

Persian-Farsi
خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفاً با شماره 1-866-260-2723 تماس بگیرید.

Polish
Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-260-2723.

Portuguese
Oferecemos serviço gratuito de assistência de idioma. Ligue para 1-866-260-2723.

Punjabi
ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-866-260-2723 'ਤੇ ਕਾਲ ਕਰੋ।

Romanian
Vi se pun la dispoziție, în mod gratuit, servicii de traducere. Vă rugăm să sunați la 1-866-260-2723.

Russian
Языковые услуги предоставляются вам бесплатно. Звоните по телефону 1-866-260-2723.

Samoan- Fa'asamoa
O loo maua fesoasoani mo gagana mo oe ma e lē totogia. Faamolemole telefoni le 1-866-260-2723.

Serbo- Croatian
Možete besplatno koristiti usluge prevodioca. Molimo nazovite 1-866-260-2723.

Somali
Adeegyada taageerada luqadda oo bilaash ah ayaa la heli karaa. Fadlan wac 1-866-260-2723.

Spanish
Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.

Sudanic- Fulfulde
E woodi walliinde dow wolde caahu ngam maaɗa. Noodu 1-866-260-2723.

Swahili
Huduma za msaada wa lugha zinapatikana kwa ajili yako bure. Tafadhali piga simu 1-866-260-2723.

Syriac- Assyrian
ܚܕ̈ܡܬܐ ܕܗܘܕܪܐ ܕܠܫܢܐ، ܡܓܢܢܐܝܬ، ܐܝܬ ܩܐܝܟ ܠܡܦܠܚܘܢ. ܩܪܝܒܘܢ ܡܢܘ ܥܠ ܡܢܝܢܐ 1-866-260-2723.

Tagalog
Ang mga serbisyo ng tulong sa wika ay available para sa iyo ng walang bayad. Mangyaring tumawag sa 1-866-260-2723.

Telugu
లాంగ్వేజ్ అసిస్టెంట్ సర్వీసెస్ మీకు ఉచితంగా అందుబాటులో ఉన్నాయి. దయ చేసి 1-866-260-2723 కి కాల్ చేయండి.

Thai
มีบริการความช่วยเหลือด้านภาษาให้โดยที่คุณไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด โปรดโทรศัพท์ถึงหมายเลข 1-866-260-2733

Tongan- Fakatonga
'Oku 'i ai pē 'a e sēvesi ki he lea' ke tokoni kiate koe pea 'oku 'atā ia ma'au 'o 'ikai ha totongi. Kātaki 'o tā ki he 1-866-260-2723.

Trukese (Chuukese)
En mei tongeni angei aninisin emon chon chiakku, ese kamo. Kose mochen kopwe kokkori 1-866-260-2723.

Turkish
Dil yardım hizmetleri size ücretsiz olarak sunulmaktadır. Lütfen 1-866-260-2723 numarayı arayınız.

Ukrainian
Послуги перекладу надаються вам безкоштовно. Дзвоніть за номером 1-866-260-2723.

Urdu
زبان کے حوالے سے معاونتی خدمات آپ کے لیے بلامعاوضہ دستیاب ہیں۔ براہ مہربانی 1-866-260-2723 پر کال کریں۔

Vietnamese
Dịch vụ hỗ trợ ngôn ngữ, miễn phí, dành cho quý vị. Xin vui lòng gọi 1-866-260-2723.

Yiddish
שפראך הילף סערוויסעס זענען אוועילעבל פאר אייך פריי פון אפצאל. ביטע רופט 1-866-260-2723.

Yoruba
Isẹ̀ ìrànlọ́wọ́ èdè tí ó jẹ́ ọ̀fẹ́, wà fún ọ. Pe 1-866-260-2723.