Highlights of the Coverage and Services

Eligibility:
All registered students taking 3 or more credit hours, included Distance Learning are eligible on voluntary. Eligible Dependents of those enrolled in plan may participate in the plan on a voluntary basis.

Deductible:
- $250 Deductible for Preferred Providers per person per policy year.
- $500 Deductible for Out of Network Providers.

Out-of-Pocket Expenses:
- $3,500 Deductible for Preferred Provider Out-of-Pocket per person per policy year.
- $7,000 Deductible for Out of Network Providers.

After the Out-of-Pocket maximum has been satisfied, UnitedHealthcare StudentResources will pay 100% up to the policy Maximum benefits. For details, please see the next page’s benefits schedule.

Need to find Preferred Providers (in Network) Physician and Hospitals?
Please use our physician locator: https://www.myuhc.com

Still have questions about Enrollment, Benefits Schedule or Prescriptions?
Please call the UnitedHealthcare StudentResources 800-767-0700 with Group ID 201723 Monday to Friday from 8:00 am - 6:00 pm EST, or send us an email jzhou@studentccsi.com
PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
NORTH CAROLINA ASSOCIATION OF COMMUNITY COLLEGES - STUDENT PLAN
2013-201723-1
INJURY AND SICKNESS BENEFITS

Maximum Benefit: $500,000 (Per Insured Person) (Per Policy Year)
Deductible Preferred Providers: $250 (Per Insured Person, Per Policy Year)
Deductible Out of Network: $500 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Providers: 80% except as noted below
Coinsurance Out of Network: 60% except as noted below
Out-of-Pocket Maximum Preferred Providers: $3,500 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out of Network: $7,000 (Per Insured Person, Per Policy Year)

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

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

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

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

### Inpatient

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

### Outpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Day Surgery Miscellaneous:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Anesthetist:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physician's Visits:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Physiotherapy:</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>(Outpatient Physiotherapy benefits payable only for condition that required surgery or Hospital Confinement: 1) within 30 days immediately preceding such Physiotherapy; or 2) within 30 days immediately following Attending Physician’s release for rehabilitation.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medical Emergency: Preferred Allowance
See Out-of-Network Medical Emergency Services, page 12.
(The Copay/ per visit Deductible will be waived if admitted to the Hospital waived if admitted.) (The Copay/per visit Deductible is in addition to Policy Deductible.)

Preferred Allowance
80% of Usual and Customary Charges
$100 Copay per visit
$100 Deductible per visit

X-rays & Laboratory:
Preferred Allowance
Usual and Customary Charges
Radiation Therapy:
Preferred Allowance
Usual and Customary Charges
Tests & Procedures:
Preferred Allowance
Usual and Customary Charges
Injections:
Preferred Allowance
Usual and Customary Charges
Chemotherapy:
Preferred Allowance
Usual and Customary Charges
*Prescription Drugs:
UnitedHealthcare Pharmacy (UHCP)
$15 Copay per prescription for Tier 1
$35 Copay per prescription for Tier 2
$70 Copay per prescription for Tier 3

Mail order Prescription Drugs through UHCP at 2.5 times the 90 day supply retail Copay.

If a retail UnitedHealthcare Pharmacy agrees to the same rates, terms and requirements associated with dispensing a 90 day supply, then up to a consecutive 90 day supply of a Prescription Drug Product at 2.5 times the copay applies to a 31 day supply per prescription.

Other
Ambulance:
Preferred Allowance
80% of Usual and Customary Charges
Durable Medical Equipment:
Preferred Allowance
Usual and Customary Charges
($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum are not included in the $500,000 Maximum Benefit.)
Consultant:
Preferred Allowance
Usual and Customary Charges
($1,000 maximum Per Policy Year.) (Benefits paid on Injury to Sound, Natural Teeth only. Benefits are not subject to the $500,000 Maximum Benefit.)
Dental:
Preferred Allowance
Usual and Customary Charges
80% of Usual and Customary Charges
Maternity:
See Benefits for Maternity Expenses
No Benefits
Complications of Pregnancy:
Paid as any other Sickness
Repatriation:
Benefits provided by FrontierMEDEX
Benefits provided by FrontierMEDEX
Medical Evacuation:
Benefits provided by FrontierMEDEX
Note Below
*AD&D:
($2,500 - $5,000 maximum)
Preventive Care Services:
100% of Preferred Allowance
[5 – 100] Copay [per visit] [per service]]

Other
Preventive Care Services:
[70\%-100\%] of [Usual and Customary Charges]
Diabetes Services:
(See Benefits for Diabetes)
Paid as any other Sickness
Paid as any other Sickness
Mental Illness Treatment:
Paid as any other Sickness
Paid as any other Sickness
Reconstructive Breast Surgery Following Mastectomy:
Paid as any other Sickness
(See Benefits for Reconstructive Breast Surgery Following Mastectomy)
Substance Use Disorder Treatment: [If elected by the Policyholder,]
See Benefits for Treatment of Chemical Dependency
See Benefits for Treatment of Chemical Disorder
Approved Clinical Trials:
See Benefits for Covered Clinical Trials
See Benefits for Covered Clinical Trials

COL-12-NC SOB PPO - 10 -
Continuation Permitted: Yes ( ) No (X)

(X) Extension of Benefits

Other Insurance: ( ) Excess Insurance (X) Primary Insurance

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

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

UnitedHealthcare Choice Plus.

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

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

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

“Network Area” means the 50 mile radius around the local school campus the Named Insured is attending.

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

Inpatient Expenses

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

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

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

Out of Network Medical Emergency Services

When Medical Emergency Services for a Medical Emergency are provided by an Out of Network Provider, benefits will be based on the billed amount but are subject to the same Copay or Coinsurance amounts that are applicable to Medical Emergency Services provided by a Preferred Provider.
EXAMPLE OF DETERMINATION OF PAYMENT OBLIGATIONS:

**Preferred Provider Benefits**
Preferred Provider Coinsurance percentage applied to the Preferred Allowance
For example, if the policy pays 90% of Preferred Allowance and the Preferred Allowance is $100; the Company’s benefit payment would be 90% x $100 = $90.
The Company would pay $90 and the Insured would be responsible for payment to the Preferred Provider of $10. The billed amount less the Preferred Allowance is an ineligible amount not owed to the Preferred Provider in accordance with an agreement between the Company and provider.

**Out of Network Benefits**
Out of Network Coinsurance percentage applied to the Usual and Customary Charge
For example, if the policy pays 80% of Usual and Customary and the Usual and Customary Charge is $100, the Company’s benefit payment would be 80% x $100 = $80.
The Company would pay $80 and the Insured would be responsible for payment to the provider of the billed amount less the amount the Company paid.

**NOTICE:** The Insured’s actual costs for Covered Medical Expenses may exceed the stated Coinsurance or Copayment amount because actual provider charges may not be used to determine Policy and Insured payment obligations.
Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any Coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

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

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

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

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

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

5. **Physiotherapy (Inpatient):** See Schedule of Benefits.

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

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

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

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

10. **Physician's Visits (Inpatient):** non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.

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

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

13. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
14. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.

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

16. **Physician's Visits (Outpatient):** benefits do not apply when related to surgery or Physiotherapy. Physician’s Visits for preventive care are provided as specified under Preventive Care Services.

17. **Physiotherapy (Outpatient):** physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy unless excluded in the policy. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.

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

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

20. **Radiation Therapy (Outpatient):** See Schedule of Benefits.

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

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

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

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

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

26. **Ambulance Services:** See Schedule of Benefits.

27. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. Durable medical equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body. If more than one prosthetic device can meet the Insured’s functional need, benefits are available only for the prosthetic device that meets the minimum specifications for the Insured’s needs. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

28. **Consultant Physician Fees:** when requested and approved by the attending Physician.

29. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.

30. **Mental Illness Treatment:** the benefits are specified in the Schedule of Benefits. Benefits will be paid for services received: 1) on an Inpatient basis while confined to a Hospital including partial hospitalization/day treatment received at a Hospital; and 2) on an outpatient basis including intensive outpatient treatment.
31. **Substance Use Disorder Treatment:** [If elected by the Policyholder,] See Benefits for Treatment of Chemical Dependency.

32. **Maternity:** Same as any other Sickness. See Benefits for Maternity Expenses.

   This policy does not cover all routine, preventive, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

   **Initial screening at first visit:**
   1) Pregnancy test: urine human chorionic gonatropin (HCG)
   2) Asymptomatic bacteriuria: urine culture
   3) Blood type and Rh antibody
   4) Rubella
   5) Pregnancy-associated plasma protein-A (PAPPA) (first trimester only)
   6) Free beta human chorionic gonadotrophin (hCG) (first trimester only)
   7) Hepatitis B: HBsAg
   8) Pap smear
   9) Gonorrhea: Gc culture
   10) Chlamydia: chlamydia culture
   11) Syphilis: RPR
   12) HIV: HIV-ab
   13) Coombs test

   **Each visit:** Urine analysis
   **Once every trimester:** Hematocrit and Hemoglobin
   **Once during first trimester:** Ultrasound
   **Once during second trimester**
   1) Ultrasound (anatomy scan)
   2) Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a
   **Once during second trimester if age 35 or over:** Amniocentesis or Chorionic villus sampling (CVS)
   **Once during second or third trimester:** 50g Glucola (blood glucose 1 hour postprandial)
   **Once during third trimester:** Group B Strep Culture

   Pre-natal vitamins are not covered.

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

34. **Preventive Care Services:** medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

35. **Reconstructive Breast Surgery Following Mastectomy:** same as any other Sickness and in connection with a covered mastectomy. See Benefits for Reconstructive Breast Surgery Following Mastectomy.

36. **Diabetes Services:** same as any other Sickness in connection with the treatment of diabetes. See Benefits for Diabetes.

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

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

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

BENEFITS FOR EMERGENCY SERVICES

Benefits will be paid the same as any other Sickness or Injury for treatment of a Medical Emergency. The Insured should use emergency services, including calling 911 or other telephone access systems utilized to access pre-hospital emergency services when appropriate for treatment of a Medical Emergency.

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

BENEFITS FOR TEMPOROMANDIBULAR JOINT DISORDER

Benefits will be paid the same as treatment to any other joint in the body for the treatment of Temporomandibular Joint Disorder (“TMJ”). Procedures will include splinting and use of intraoral prosthetic appliances to reposition the bones. Non-surgical treatment of TMJ is subject to a lifetime maximum benefit of $3,500. No benefits will be paid for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, root canal or routine dental treatment.

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

BENEFITS FOR CERVICAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for Examinations and Laboratory Tests for the screening for the early detection of cervical cancer. Benefits shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control and will include the examination, laboratory fee, and the Physician’s interpretation of the laboratory results.

Reimbursement for the laboratory fee will be made only if the laboratory meets accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.

“Examinations and laboratory tests” means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

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

BENEFITS FOR MAMMOGRAPHY

Benefits will be paid the same as any other Sickness for Low-dose Screening Mammography according to the following guidelines:

1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this benefit, "at risk" means the following:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman's mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30.

2. One baseline mammogram for any woman thirty-five through thirty-nine years of age, inclusive.

3. A mammogram every other year for any woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Physician.

4. A mammogram every year for any woman fifty years of age or older.

Reimbursement will be made only if the facility where treatment is rendered meets the mammography accreditations standards established by the North Carolina Medical Care Commission or United States Department of Health and Human Services.
"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician's interpretation of the results of the procedure.

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

**BENEFITS FOR SURVEILLANCE TESTS FOR WOMEN AT RISK FOR OVARIAN CANCER**

Benefits will be paid the same as any other Sickness for Surveillance Tests for women age 25 and older At Risk for Ovarian Cancer.

“At risk for ovarian cancer” means either: a) having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2) testing positive for a hereditary ovarian cancer syndrome.

“Surveillance tests” mean annual screening using: a) transvaginal ultrasound, and 2) rectovaginal pelvic examination.

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

**BENEFITS FOR COLORECTAL CANCER SCREENING**

Benefits will be paid the same as any other Sickness for Colorectal Cancer Screening. Beginning at age 50, benefits will be provided for non-symptomatic Insured Persons for one of the five screening options below:

1. Yearly fecal occult blood test (FOBT); or
2. Flexible sigmoidoscopy every five (5) years; or
3. Yearly fecal occult blood test plus flexible sigmoidoscopy every five (5) years; or
4. Double contract barium enema every five (5) years; or
5. Colonoscopy every ten (10) years.

In addition, upon recommendation of the Physician, medically necessary benefits will be provided for one or more of the screening options, based on American Cancer Society guidelines regarding family history or other factors, regardless of the age of the Insured.

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

**BENEFITS FOR PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS**

Benefits will be paid the same as any other Sickness for prostate-specific antigen (PSA) or equivalent tests for the presence of prostate cancer when recommended by a Physician.

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

**BENEFITS FOR RECONSTRUCTIVE BREAST SURGERY FOLLOWING MASTECTOMY**

Benefits will be paid the same as any other Sickness for Reconstructive Breast Surgery following a Mastectomy. Benefits will be paid for all stages and revisions of Reconstructive Breast Surgery performed on a diseased breast, as well as for prostheses and physical complications in all stages of Mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a Mastectomy is covered without regard to the lapse of time between the Mastectomy and the reconstruction upon approval by the treating Physician.

“Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.

“Reconstructive breast surgery” means surgery performed as a result of a Mastectomy to re-establish symmetry between the two breasts, and includes reconstruction of the Mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. “Reconstructive breast surgery” also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

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

Benefits will be paid the same as any other Sickness for medically necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures, used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician or healthcare professional designated by the Physician.

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

BENEFITS FOR ANESTHESIA AND HOSPITALIZATION FOR DENTAL PROCEDURES

Benefits will be paid the same as any other Sickness for anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the Physician treating the Insured involved certifies that, because of the Insured’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.

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

BENEFITS FOR BONE MASS MEASUREMENT

Benefits will be paid the same as any other Sickness for a Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass for Qualified Individuals.

Benefits will be paid for one Bone Mass Measurement every 23 months. Benefits will be paid more frequently when medically necessary. Conditions that may be considered medically necessary include, but are not limited to: 1) monitoring beneficiaries on long-term glucocorticoid therapy of more than three months and 2) to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

“Bone mass measurement” means a scientifically proven radiologic, radioisotopic, or other procedure performed on a Qualified Individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

“Qualified individual” means any one or more of the following:
- an individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass;
- an individual with radiographic osteopenia anywhere in the skeleton;
- an individual who is receiving long-term glucocorticoid (steroid) therapy;
- an individual who primary hyperparathyroidism;
- an individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies;
- an individual who has a history of low-trauma fractures; or
- an individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

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

BENEFITS FOR PRESCRIPTION CONTRACEPTIVES

If the Policy provides coverage for prescription drugs or devices, benefits will be paid the same as any other prescription drug or device for any contraceptive drug or device including the insertion or removal and any medical examination associated with the use of such contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid the same as any other Sickness for outpatient contraceptive services provided by a Physician.

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

BENEFITS FOR NEWBORN HEARING SCREENING

Benefits will be paid the same as any other Sickness for Physician ordered newborn hearing screening.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.
BENEFITS FOR THE TREATMENT OF LYMPHEDEMA

Benefits will be paid the same as any other Sickness for the diagnosis, evaluation, and treatment of lymphedema including equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a Physician.

Gradient Compression Garments:

1. require a prescription;
2. are custom-fit for the Insured Person; and
3. do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

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

BENEFITS FOR HEARING AIDS

Benefits will be paid for one hearing aid per hearing-impaired ear up to $2,500 per hearing aid every 36 months when Medically Necessary and ordered by a Physician or audiologist licensed in the state. Coverage includes:

1. Initial hearing aids and replacement hearing aids not more frequently than every 36 months.
2. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the Insured Person.
3. Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

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

BENEFITS FOR COVERED CLINICAL TRIALS

Benefits will be paid the same as any other Sickness for participation in phase I, phase II, phase III, and phase IV Covered Clinical Trials by an Insured who meets protocol requirements of the trials and when informed consent is provided.

Only Covered Medical Expenses for the costs of health care services which are a Medical Necessity and associated with participation in a Covered Clinical Trial, including those related health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and medically necessary monitoring will be paid and only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials.

No benefits will be provided for non-FDA approved drugs provided or made available to an Insured patient who received the drug during a Covered Clinical Trial after the clinical trial has been discontinued.

The following clinical trial costs are not covered:

1. Costs of services that are not health care services;
2. Cost of services provided solely to satisfy data collection and analysis needs;
3. Costs of services related to investigation drugs and devices; and
4. Costs of services that are not provided for the direct clinical management of the Insured patient.

“Covered Clinical Trials” means phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

1. involve the treatment of life-threatening medical conditions;
2. are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives;
3. have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives;
4. must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties;
5. must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs; and

6. must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

In the event a claim contains charges related to services for which coverage is required under this benefit, and those charges cannot be separated from costs related to services that are not covered under this benefit, the Company shall deny the claim.

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

**BENEFITS FOR MATERNITY EXPENSES**

Benefits will be paid the same as any other Sickness for Inpatient and outpatient maternity care.

Inpatient benefits will include:

1. A minimum of forty-eight (48) hours of inpatient care following a vaginal delivery for the mother and her Newborn Infant after childbirth; and

2. A minimum of ninety-six (96) hours of inpatient care following a cesarean section for the mother and Newborn Infant after childbirth.

If the mother agrees, the attending Physician may discharge the mother earlier than these minimum time frames. In the case of a decision to discharge the mother and her Newborn Infant from the Inpatient setting before the expiration of 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, benefits will include Timely Postdelivery Care. Timely Postdelivery Care shall be provided to a mother and her Newborn Infant by a registered nurse, Physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health. Such follow-up care shall be provided in:

1. The home, a provider’s office, a Hospital, a birthing center, an immediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or

2. Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

“Timely PostDelivery Care” means health care that is provided:

1. Following the discharge of a mother and her Newborn Infant from the Inpatient setting; and

2. In a manner that meets the health care needs of the mother and her Newborn Infant, which provides for the appropriate monitoring of the conditions of the mother and Newborn Infant, and occurs not later than the 72-hour period immediately following discharge.

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

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

1. Acne;
2. Acupuncture;
3. Allergy, including allergy testing;
4. Nicotine addiction, except as specifically provided in the policy;
5. Milieu therapy, learning disabilities, behavioral problems, intensive behavioral therapies, such as applied behavioral analysis; parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the policy;
6. Biofeedback;
7. Circumcision, except as specifically provided for a Newborn Infant during an Inpatient maternity hospital stay provided under the Benefits for Maternity Expenses;
8. Congenital conditions, except as specifically provided for Newborn Infant or Adopted or Foster Child;
9. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for a Newborn Infant or Adopted or Foster Child;
10. 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;
11. Dental treatment, except for accidental Injury to Sound, Natural Teeth. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;
12. Elective Surgery or Elective Treatment;
13. Elective abortion;
14. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;
15. Flat foot conditions; supportive devices for the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
16. Health spa or similar facilities; strengthening programs;
17. Hearing examinations, except as specifically provided in the Benefits for Newborn Hearing Screening; hearing aids, except as specifically provided in the Benefits for Hearing Aids; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;
18. Hirsutism; alopecia;
19. Hypnosis;

20. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit;

21. Injury caused by, contributed to, or resulting from the use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;

22. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers’ Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers’ compensation insurance carrier according to a final adjudication under the North Carolina Workers’ Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act;

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

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

25. Investigational services, except as specifically provided in the Benefits for Covered Clinical Trials;

26. Lipectomy;

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

28. Voluntary participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting, except when as a direct result of domestic abuse;

29. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous Creditable Coverage under a prior health insurance policy. This exclusion will not be applied to an Insured Person who is under age 19;

30. Prescription Drugs, services or supplies as follows:
   a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
   b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;
   c) Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs, except for drugs for the treatment of cancer that have not been approved by the Federal Food and Drug Administration, provided the drug is recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (2) The ThomsonMicromedex DrugDex; (3) The Elsevier Gold Standard’s Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services;
   d) Products used for cosmetic purposes;
   e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
   f) Anorectics - drugs used for the purpose of weight control;
   g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
   h) Growth hormones, except for a Newborn Infant, Adopted or Foster Child who requires growth hormones for the treatment of a congenital condition; or
   i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
31. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures; except as specifically provided in the policy;

32. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Benefits for Covered Clinical Trials;

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

34. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or any North Carolina mandated benefit included under this policy;

35. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

36. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;

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

38. Sleep disorders;

39. Speech therapy; naturopathic services;

40. Suicide or attempted suicide while sane or insane (including intentional drug overdose); or intentionally self-inflicted Injury;

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

42. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;

43. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

44. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and

45. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat. This exclusion does not apply to any screening or assessment specifically provided under the Preventive Care Services benefit or any North Carolina mandated benefit included under this policy.
PART X
REBATES / INDUCEMENTS

From time to time the Company may offer or provide certain persons who become Insureds with the Company with discounts for goods or services. In addition, the Company may arrange for third party service providers such as pharmacies, optometrists, and dentists to provide discounted goods and services to those persons who become Insureds of the Company. While the Company has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to the Insureds for the provision of such goods and/or services. The Company is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Company is not liable to the Insured for the negligent provision of such goods and/or services by the third party service providers.

PART XI
PRE-EXISTING CONDITION PROVISION

Pre-existing Condition Limitations
This policy contains a provision limiting coverage for Pre-existing Conditions. Pre-existing Conditions are covered under this policy [12 months] after the Insured’s effective date of coverage under the school’s student insurance policy. Pre-existing Conditions means those conditions for which medical advice, diagnosis, care, or treatment was received or recommended within a [12 month period] immediately preceding the Insured’s Effective Date under the policy.

This Pre-existing Condition Limitation does not apply to an Insured Person who is under age 19 including a Newborn Infant, Adopted or Foster Child.

[Creditable Coverage
The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured provides documentation of continuous Creditable Coverage under a prior health insurance policy. [The coverage must be continuous to a date within [30 – 120] days prior to the Insured’s effective date under this policy.]

There is no time limit on the amount of time an Insured has to present a certificate or evidence of Creditable Coverage.]]
POLICY ENDORSEMENT

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

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

For Loss of:

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

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

The Accidental Death benefit is payable for the involuntary inhalation of gas and fumes and the involuntary taking of poison.

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

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

PRE-ADMISSION NOTIFICATION

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

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

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

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

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

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

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

UnitedHealthcare Pharmacy Prescription Drug Benefits

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

Copayment and/or Coinsurance Amount

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

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

Supply Limits

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

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

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

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling Customer Service 1-855-828-7716.

You cannot refill a prescription until 75% of the applicable supply limit has been used, except under certain circumstances during a state of emergency or disaster.

If a Brand-name Drug Becomes Available as a Generic

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

Notification Requirements

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

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

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.uhcsr.com or by calling Customer Service at 1-855-828-7716.
If the Company is not notified before the Prescription Drug Product is dispensed, the Insured can ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product. The Insured will be required to pay for the Prescription Drug Product at the pharmacy.

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

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

Limitation on Selection of Pharmacies

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

Coverage Policies and Guidelines

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

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

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

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

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

Rebates and Other Payments

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

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

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

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

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

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

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

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

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

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

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

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

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.
**Prescription Drug or Prescription Drug Product** means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

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

**Prescription Drug List** means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company’s periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call **Customer Service** at 1-855-828-7716.

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

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

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

**Additional Exclusions**

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

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

2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.

3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.

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

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

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

DEFINITIONS

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

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

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

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

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

Grievance means a written complaint submitted by or on behalf of an Insured Person regarding:
1. The Company’s decisions, policies, or actions related to availability, delivery or quality of health care services;
2. Claims payment, handling or reimbursement for health care services;
3. The contractual relationship between an Insured Person and the Company; or
4. The outcome of an Adverse Determination as defined.

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

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

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
1. Could seriously jeopardize the life or health of the Insured Person or the ability of the Insured Person to regain maximum function; or
2. In the opinion of a physician with knowledge of the Insured Person’s medical condition, would subject the Insured Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

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

INFORMAL REVIEW
An Insured Person may submit a Grievance to the Company for informal review after an event that causes a dispute.
1) If the Grievance concerns a clinical issue and the informal consideration decision is not in favor of the Insured, the Company shall on the day the decision is made or on the tenth business day after receipt of the request for informal consideration, whichever is sooner, provide the Insured with information on how to submit written material for an Internal Appeal.

2) If the Grievance concerns a nonclinical issue and the informal consideration decision is not in favor of the Insured, the Company shall issue a written decision that includes the availability of the Commissioner’s office and the Managed Care Assistance Program for assistance, including the telephone number and address of the office of both.

3) If the Company is unable to render an informal consideration decision within 10 business days after receipt of the Grievance, the Company on the day the Company determines an informal consideration decision cannot be made before the tenth business day after receipt of the Grievance, the Company will provide the Insured with information on how to submit written material for an Internal Appeal.

**INTERNAL APPEAL PROCESS**

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

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

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

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

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

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

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

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

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

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

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

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

Expedited Internal Review (EIR) of an Adverse Determination

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

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

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

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

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

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

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

EXTERNAL INDEPENDENT REVIEW

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

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

A request for an External Independent Review shall not be made until the Insured Person or Authorized Representative has exhausted the Internal Appeals process. The Internal Appeal Procedure shall be considered exhausted if:
1. The Company has issued a Final Adverse Determination as detailed herein;
2. The Insured Person or the Authorized Representative filed a request for an Internal Appeal and has not received a written decision from the Company within 30 days and the Insured Person or Authorized Representative has not requested or agreed to a delay;
3. The Company fails to strictly adhere to the Internal Appeal process detailed herein; or
4. The Company agrees to waive the exhaustion requirement.

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 120 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 Commissioner. Upon request of an External Review, the Commissioner shall provide the Insured Person or the Authorized Representative with the appropriate forms to request the review.

I. Standard External Review (SER) Process

1. Within 10 business days after receiving the SER request notice, the Commissioner will notify the Company of the request for SER and request the Company deliver to the Commissioner any information needed to 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. The Commissioner shall notify the Company, 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 Commissioner’s response shall include what information or materials are needed to make the request complete;
   b. If the request is not eligible, the Commissioner’s response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.
3. After receiving notice that a request is eligible for SER, the Commissioner shall:
   a. Assign an Independent Review Organization (IRO) from the Commissioner’s approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 150 days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.
4. a. The Company shall, within 7 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company’s failure to provide the documents and information will not delay the SER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall, within 1 business day, advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.
5. The IRO shall review all written information and documents submitted by the Company and the Insured Person or the Authorized Representative.
6. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.
   a. The Company may then reconsider its Adverse Determination or Final Adverse Determination. Reconsideration by the Company shall not delay or terminate the SER.
   b. The SER may only be terminated if the Company decides to reverse its Adverse Determination or Final Adverse Determination and provide coverage for the service that is the subject of the SER.
   c. If the Company reverses its decision, the Company shall provide written notification within 1 business day to the Commissioner, the Insured Person, the Authorized Representative, if applicable, and the IRO. Upon written notice from the Company, the IRO will terminate the SER.
7. Within 45 days after receipt of the SER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.
II. Expedited External Review (EER) Process

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

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

2. Upon receipt of an EER request, the Commissioner shall, within 3 business days send a copy of the request to the Company and request the Company deliver to the Commissioner, no later than one business day after request, any information needed to determine that:
   a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;
   b. the Insured Person has exhausted the Company’s Internal Appeal Process, unless the Insured Person is not required to do so as specified in sections II. 1. a. and b. shown above;
   c. the Insured Person has provided all the information and forms necessary to process the request; and
   d. the service in question: (i) is a Covered Medical Expense under the Policy; and (ii) is not covered because it does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

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

4. When a request is complete and eligible for an EER, the Commissioner shall immediately assign an IRO from the Commissioner’s approved list and notify the Company of the name of the assigned IRO.
   a. The Company shall, within the same business day of receiving notice, 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 4 business days after receipt of the qualifying EER request, the IRO shall:
   a. Make a decision to uphold or reverse the Adverse Determination or Final Adverse Determination; and
   b. Notify the Commissioner, the Company, the Insured Person, and, if applicable, the Authorized Representative.

7. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately, within 1 business day, approve the coverage that was the subject of the Adverse Determination or Final Adverse Determination.

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

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

2. Within 10 business days after receiving the SEIER request notice, the Commissioner will notify the Company of the request for SEIER and request the Company to deliver to the Commissioner any information needed to complete a preliminary review to determine that:
a. the individual was an Insured Person covered under the Policy at the time the service was recommended, requested or provided;  

b. the recommended or requested health care services or treatment:
   (i) is a Covered Medical Expense under the Insured Person’s Policy except for the Company’s determination that the service or treatment is experimental or investigational for a particular medical condition; and
   (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person’s Policy;

c. the Insured Person’s treating Physician has certified that one of the following situations is applicable:
   (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
   (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
   (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;

d. the Insured Person’s treating Physician:
   (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician’s opinion, than any available standard health care services or treatments; or
   (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person’s condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;

e. the Insured Person has exhausted the Company’s Internal Appeal Process; and

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

3. The Commissioner shall notify the Company, 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 Commissioner’s response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Commissioner’s response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.

4. After receiving notice that a request is eligible for SEIER, the Commissioner shall:

   a. Assign an IRO from the Commissioner’s approved list;
   b. Notify the Company of the name of the assigned IRO; and
   c. Notify the Insured Person and, if applicable, the Authorized Representative, that the request has been accepted. This notice shall include: (i) the name of the IRO; and (ii) a statement that the Insured Person or the Authorized Representative may, within 150 days following receipt of the notice, submit additional information to the IRO for consideration when conducting the review.

5. a. The Company shall, within 7 business days, provide the IRO with any documents and information the Company considered in making the Adverse Determination or Final Adverse Determination. The Company’s failure to provide the documents and information will not delay the SEIER.
   b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.

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

7. If the IRO receives any additional information from the Insured Person or the Authorized Representative, the IRO must forward the information to the Company within 1 business day.

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

8. Within 45 days after receipt of the SEIER request, the IRO shall provide written notice of its decision to uphold or reverse the Adverse Determination or Final Adverse Determination. The notice shall be sent to the Commissioner, the Company, the Insured Person and, if applicable, the Authorized Representative.

9. Upon receipt of a notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall immediately approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.
IV. Expedited Experimental or Investigational Treatment External Review (EEIER) Process

1. An Insured Person or an Authorized Representative may make a written or an oral request for an Expedited Experimental or Investigational Treatment External Review (EEIER) with the Commissioner at the time the Insured Person receives:

   a. An Adverse Determination if:
      (i) The Insured Person or the Authorized Representative has filed a request for an Expedited Internal Review (EIR); and
      (ii) The Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person’s treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or

   b. A Final Adverse Determination, if:
      (i) The Insured Person has a medical condition for which the timeframe for completing a Standard External Review (SER) would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
      (ii) The Final Adverse Determination is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person’s treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

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

2. Upon receipt of an EEIER request notice, the Commissioner shall, within 3 business days, send a copy of the request to the Company and request the Company deliver to the Commissioner, no later than one business day after request, any information needed to complete a preliminary review to determine that:

   a. the individual was an Insured Person covered under the Policy at the time the service was recommended or provided;
   b. the recommended or requested health care services or treatment:
      (i) is a Covered Medical Expense under the Insured Person’s Policy except for the Company’s determination that the service or treatment is experimental or investigational for a particular medical condition; and
      (ii) is not explicitly listed as an Exclusion or Limitation under the Insured Person’s Policy;
   c. the Insured Person’s treating Physician has certified that one of the following situations is applicable:
      (i) standard health care services or treatments have not been effective in improving the condition of the Insured Person;
      (ii) standard health care services or treatments are not medically appropriate for the Insured Person;
      (iii) there is no available standard health care service or treatment covered by the Company that is more beneficial than the recommended or requested health care service or treatment;
   d. the Insured Person’s treating Physician:
      (i) has recommended a health care service or treatment that the Physician certified, in writing, is likely to be more beneficial to the Insured Person, in the Physician’s opinion, than any available standard health care services or treatments; or
      (ii) who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Insured Person’s condition, has certified in writing that scientifically valid studies using acceptable protocols demonstrate that the health care service or treatment requested by the Insured Person is likely to be more beneficial to the Insured Person than any available standard health care services or treatments;
   e. the Insured Person has exhausted the Company’s Internal Appeal Process unless the Insured person is not required to do so as specified in Section IV. 1. a. and b. above; and
   f. the Insured Person has provided all the information and forms necessary to process the request.

3. The Commissioner shall immediately notify the Company, 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 Commissioner’s response shall include what information or materials are needed to make the request complete; or
   b. If the request is not eligible, the Commissioner’s response shall include the reasons for ineligibility. The Insured Person and, if applicable, the Authorized Representative shall also be advised of the right to appeal the decision to the Commissioner.

4. After receiving notice that a request is eligible for EEIER, the Commissioner shall immediately:

   a. Assign an IRO from the Commissioner’s approved list; and
   b. Notify the Company of the name of the assigned IRO.

5. 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.
6. a. The Company shall, within the same business day of receiving request, provide the IRO with any documents and information the Company 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. The Company’s failure to provide the documents and information will not delay the EEIER.

b. If the Company fails to provide the documents and information within the required time frame, the IRO may terminate the review and may reverse the Adverse Determination or Final Adverse Determination. Upon making this decision, the IRO shall immediately advise the Commissioner, the Company, the Insured Person, and the Authorized Representative, if any, of its decision.

7. 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.

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

9. The IRO shall make a decision and provide oral or written notice of its decision within 4 business days after receipt of the opinions from each clinical reviewer.

10. Upon receipt of the IRO’s notice of decision reversing the Adverse Determination or Final Adverse Determination, the Company shall, within 1 business day, approve the coverage of the recommended or requested health care service or treatment that was the subject of the Adverse Determination or Final Adverse Determination.

**BINDING EXTERNAL REVIEW**

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