2016-2017
International Student
Injury and Sickness
Insurance Plan

Excess Insurance
Designed Exclusively for International Students

Global Travelers Organization SP

PSI – Platinum High School Plan

Underwritten by:
Student Resources (SPC) Ltd.
A UnitedHealth Group Company
Administered by
UnitedHealthcare StudentResources
PO Box 809025
Dallas, TX 75380-9025

Referred and Administered By:
Professional Service, Inc.
PSI Health Insurance
www.psiservice.com

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Eligibility

All International students attending a High School registered for credit courses are eligible to enroll in the plan. The credit course requirement is waived for the Summer if the International Student is enrolled in ESL courses/or enrolled for the Fall Semester.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

U.S. citizens are not eligible for coverage.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., July 1, 2016. The individual student’s coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., September 30, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Twelve (12) months is the maximum time coverage can be effective under any policy year for any Insured person.

Refunds of premiums are allowed only upon entry into the armed forces.

Choice of Plan

Each eligible student has a choice of one of two Global Traveler Organization Injury and Sickness Plans: Gold and Platinum. This brochure provides information on the Platinum Plan (2016-202897-1). The Platinum Plan has higher benefits than the Gold Plan, and it has a higher premium.

Please review the benefits and make your selection carefully. You cannot upgrade coverage after the initial purchase of the plan for the policy year.

The Gold Plan (2016-202897-2) is outlined in a separate brochure.

Premium Rates

<table>
<thead>
<tr>
<th>2016-202897-1</th>
<th>$0/$150 Deductible</th>
<th>$0/$150 Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twelve Month Rates</td>
<td>30-Day Rates</td>
<td>30 – Day rates</td>
</tr>
<tr>
<td>Student</td>
<td>$ 980.00</td>
<td>Student-24 and Under</td>
</tr>
</tbody>
</table>

To enroll in this Plan, please visit PSI Health Insurance at www.psiservice.com.

Extension of Benefits after Termination

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

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

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

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 Options PPO.

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 1-888-302-6182 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. Insured’s 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 Options PPO United Behavioral Health (UBH) facilities. Call 1-888-302-6182 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 Options PPO 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.
Schedule of Medical Expense Benefits

Injury and Sickness Benefits

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

<table>
<thead>
<tr>
<th>Deductible Preferred Provider</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible Out-of-Network</td>
<td>$150 (For each Injury or Sickness)</td>
</tr>
<tr>
<td>Coinsurance Preferred Provider</td>
<td>80% except as noted below</td>
</tr>
<tr>
<td>Coinsurance Out-of-Network</td>
<td>70% except as noted below</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Preferred Providers</td>
<td>$6,350 (Per Insured Person, Per Policy Year)</td>
</tr>
</tbody>
</table>

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

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

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

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

Please review the benefits and make your selection carefully. You cannot upgrade coverage after the initial purchase of the plan for the policy year.

Student Health Center Benefits: All Deductibles and Copays will be waived when treatment is rendered at the Student Health Center and paid as In-Network Coinsurance but at Usual and Customary Charges.

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. Covered Medical Expenses include:

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.</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 Expenses, 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.</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>Inpatient</td>
<td>Preferred Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Surgery</strong>, 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.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Anesthesiologist</strong>, professional services administered in connection with inpatient surgery.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Registered Nurse’s Services</strong>, private duty nursing care.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Physician’s Visits</strong>, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Pre-admission Testing</strong>, payable within 3 working days prior to admission.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Preferred Provider</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery</strong>, 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.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Day Surgery Miscellaneous</strong>, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Anesthesiologist Services</strong>, professional services administered in connection with outpatient surgery.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Physician’s Visits</strong>, benefits for Physician’s Visits do not apply when related to surgery or Physiotherapy.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Physiotherapy</strong>, 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. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Preferred Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------------------</td>
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</tr>
<tr>
<td><strong>Medical Emergency Expenses</strong>, 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.</td>
<td>Preferred Allowance $100 Copay per visit</td>
<td>Usual and Customary Charges $100 Deductible per visit</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray Services</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Tests &amp; Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>No Benefits</td>
<td>70% of Usual and Customary Charges up to a 31-day supply per prescription (The Policy Deductible does not apply.)</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>Preferred Allowance</td>
<td>80% of Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong>, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. 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. ($10,000 maximum Per Policy Year)</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Consultant Physician Fees</strong></td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Dental Treatment</strong>, made necessary by Injury to Sound, Natural Teeth only. ($250 maximum per tooth) ($1,000 maximum Per Policy Year)</td>
<td>70% of Preferred Allowance</td>
<td>70% of Usual and Customary Charges</td>
</tr>
<tr>
<td><strong>Mental Illness Treatment</strong>, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td><strong>Substance Use Disorder Treatment</strong>, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Other</td>
<td>Preferred Provider</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Complications of Pregnancy</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Elective Abortion, ($1,500 maximum Per Policy Year)</td>
<td>Preferred Allowance</td>
<td>Usual and Customary Charges</td>
</tr>
<tr>
<td>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.</td>
<td>100% of Preferred Allowance</td>
<td>No Benefits</td>
</tr>
<tr>
<td>Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
</tbody>
</table>
### Other

<table>
<thead>
<tr>
<th>Diabetes Services, in connection with the treatment of diabetes for Medically Necessary: 1) outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals; and 2) Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider: Paid as any other Sickness</td>
</tr>
<tr>
<td>Out-of-Network: Paid as any other Sickness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care Center, facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider: Preferred Allowance $50 Copay per visit</td>
</tr>
<tr>
<td>Out-of-Network: Usual and Customary Charges $50 Deductible per visit</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Approved Clinical Trials, routine patient care costs incurred during participation in an approved clinical trial for the treatment of cancer or other life-threatening condition.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider: Paid as any other Sickness</td>
</tr>
<tr>
<td>Out-of-Network: Paid as any other Sickness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Habilitative Services for the Treatment of Congenital or Genetic Birth Defects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider: See Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects</td>
</tr>
<tr>
<td>Out-of-Network: See Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Voluntary HIV Screening During Emergency Room Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Provider: See Benefits for Voluntary HIV Screening During Emergency Room Visit</td>
</tr>
<tr>
<td>Out-of-Network: See Benefits for Voluntary HIV Screening During Emergency Room Visit</td>
</tr>
</tbody>
</table>

### Additional Benefits

**Benefits for Habilitative Services for the Treatment of Congenital or Genetic Birth Defects**

Benefits will be paid the same as any other Sickness for Habilitative Services for the treatment of Congenital or Genetic Birth Defects for an Insured Person to age 21 years.

For the purposes of this benefit:

Congenital or Genetic Birth Defect means: a defect existing at or from birth including a hereditary defect including autism or an autism spectrum disorder and cerebral palsy.

Habilitative Services means: services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the Insured Person’s ability to function.

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

**Benefits for Voluntary HIV Screening Test during Emergency Room Visit**

Benefits will be paid for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits shall include one emergency department HIV screening test; the cost of administering such test, all laboratory expenses to analyze the test; the cost of communicating to the Insured the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive services. Benefits shall not be subject to any Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.
HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

a) Conducting a rapid-result test by means of the swabbing of a patient’s gums, finger-prick blood test, other suitable rapid result test and
b) If the result is positive, conducting an additional blood test for submission to a laboratory to confirm the results of the rapid-result test.

**Excess Provision**

Even if you have other insurance, the Plan may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance. Benefits will be paid on the unpaid balances after your other insurance has paid.

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first $100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

**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.

- Life: $15,000
- Two or More Members: $15,000
- One Member: $12,500

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.

**Definitions**

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

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

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

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.
DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

INJURY means bodily injury which is all of the following:

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

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

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable under this policy.

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

1. Death.
3. Serious impairment of bodily functions.
4. Serious dysfunction of any body organ or part.
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

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

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

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

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

SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy’s Effective Date will be considered a sickness under this policy.
USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

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. Assistant Surgeon Fees;
5. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation;
6. Injections;
7. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn children;
8. 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;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment;
11. 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;
12. Health spa or similar facilities; strengthening programs;
13. Hearing examinations; hearing aids; or cochlear implants; 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;
14. 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;
15. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
16. Injury or Sickness inside the Insured's home country;
17. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except when traveling for academic study abroad programs, pleasure or to or from the Insured's home country;
18. Injury or Sickness when claims payment and/or coverage is prohibited by applicable law;
19. Injury sustained while (a) participating in any intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
20. Investigational services;
21. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
22. 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 policy;
   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;
   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 Parodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
   h) Growth hormones; or
   i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. 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;

24. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy;

25. Routine Newborn Infant Care, well-baby nursery and related Physician charges; in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;

26. 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;

27. Services provided normally without charge by the Health Service of the institution attended by the Insured; or services covered or provided by a student health fee;

28. Temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;

29. 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;

30. Sleep disorders;

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

32. Travel in or upon, sitting in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limiting to: two- or three-wheeled motor vehicle; four-wheeled all-terrain vehicle (ATV); snowmobile;

33. Skiing; scuba diving;

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

35. 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

36. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, except as specifically provided in the policy.

**UnitedHealthcare Global: Global Emergency Services**

If you are a member insured with this insurance plan, you are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International students: you are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by UnitedHealthcare Global: any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

**Key Services include:**

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to 5,000.00 payment (when included with Your enrollment in a Student Resources (SPC) Ltd., a UnitedHealth Group Company health insurance policy)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit www.uhcsr.com for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

To access services please call:
(800) 527-0218 Toll-free within the United States
(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at assistance@UHCGlobal.com.

When calling the UnitedHealthcare Global Operations Center, please be prepared to provide:

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

UnitedHealthcare Global is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information in My Account at www.uhcsr.com for additional information, including limitations and exclusions.

**Online Access to Account Information**

Student Resources (SPC) Ltd., a UnitedHealth Group Company Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to My Account at www.uhcsr.com. Insured students who don’t already have an online account may simply select the “My Account” link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of Student Resources (SPC) Ltd., a UnitedHealth Group Company environmental commitment to reducing waste, we’ve adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student’s personal health information.

*My Account* now includes Message Center - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student’s email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

**ID Cards**
One way we are becoming greener is to no longer automatically mail out **ID Cards**. Instead, we will send an email notification when the digital ID card is available to be downloaded from **My Account**. An Insured student may also use **My Account** to request delivery of a permanent ID card through the mail.

**UHCSR Mobile App**

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

- **ID Cards** – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- **Provider Search** – search for In-Network participating Healthcare or Mental Health providers, call the office or facility; view a map.
- **Find My Claims** – view claims received within the past 60 days for both the primary insured and covered dependents; includes Provider, date of service, status, claim amount and amount paid.

**UnitedHealth Allies**

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to **My Account** as described above and select **UnitedHealth Allies Plan** to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

**Pediatric Dental Services Benefits**

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

**Section 1: Accessing Pediatric Dental Services**

**Network and Non-Network Benefits**

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

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

Insured Persons must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to a Network Dental Provider.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 877-816-3596 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured's ID card.

**Non-Network Benefits** apply when Covered Dental Services are obtained from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. As a result, an Insured Person may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. In addition, when Covered Dental Services are obtained from non-Network Dental Providers, the Insured must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

**Covered Dental Services**
Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

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

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

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy.

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

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

Section 2: Benefits for Pediatric Dental Services

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

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

Dental Services Deductible
Benefits for pediatric Dental Services are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is $500 per Insured Person.

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

Out-of-Pocket Maximum
Any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this benefit applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for pediatric Dental Services under this benefit applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.
**Benefits**

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

<table>
<thead>
<tr>
<th>Benefit Description and Limitations</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
<td>Benefits are shown as a percentage of Eligible Dental Expenses.</td>
</tr>
</tbody>
</table>

**Diagnostic Services**

- Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 1 series of films per 12 months.
  - 50%
  - 50%

- Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.
  - 50%
  - 50%

- Periodic Oral Evaluation (Checkup Exam) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.
  - 50%
  - 50%

**Preventive Services**

- Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.
  - 50%
  - 50%

- Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.
  - 50%
  - 50%

- Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.
  - 50%
  - 50%

- Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.
  - 50%
  - 50%

**Minor Restorative Services, Endodontics, Periodontics and Oral Surgery**

- Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.
  - 50%
  - 50%

- Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.
  - 50%
  - 50%

- Endodontics (Root Canal Therapy)
  - 50%
  - 50%

- Periodontal Surgery (Gum Surgery) Limited to one quadrant or site per 36 months per surgical area.
  - 50%
  - 50%

- Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.
  - 50%
  - 50%

- Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.
  - 50%
  - 50%

- Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.
  - 50%
  - 50%

- Oral Surgery, including Surgical Extraction
  - 50%
  - 50%

**Adjuvantive Services**

- General Services (including Dental Emergency treatment) Covered as a separate benefit only if no other service was done during the visit other than X-rays.
  - 50%
  - 50%

- General anesthesia is covered when clinically necessary.

- Occlusal guards limited to 1 guard every 12 months.
Benefit Description and Limitations | Network Benefits | Non-Network Benefits
--- | --- | ---
**Benefit Description and Limitations**

**Network Benefits**
Benefits are shown as a percentage of Eligible Dental Expenses.

**Non-Network Benefits**
Benefits are shown as a percentage of Eligible Dental Expenses.

### Major Restorative Services
Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.

<table>
<thead>
<tr>
<th>Description</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inlays/Onlays/Crowns (Partial to Full Crowns)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed Prosthetics (Bridges)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removable Prosthetics (Full or partial dentures)</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relining and Rebasing Dentures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Implants

<table>
<thead>
<tr>
<th>Description</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implant Placement</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Supported Prosthetics</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implant Maintenance Procedures</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repair Implant Supported Prosthesis by Report</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repair Implant Abutment by Support</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiographic/Surgical Implant Index by Report</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Limited to 1 time per 60 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### MEDICALLY NECESSARY ORTHODONTICS

Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon’s syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company’s dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

All orthodontic treatment must be prior authorized.

<table>
<thead>
<tr>
<th>Description</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Services</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Section 3: Pediatric Dental Exclusions**

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

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

**Section 4: Claims for Pediatric Dental Services**

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

**Reimbursement for Dental Services**

The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.
Claim Forms
It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

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

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

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

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

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-877-816-3596. This number is also listed on the Insured’s Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services
The following definitions are in addition to the policy DEFINITIONS:

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

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

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

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

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the Company’s contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary Fees, as defined below.
Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

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

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

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

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

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

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

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

Pediatric Vision Care Services Benefits

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

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.
When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

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

**Network Benefits**

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

**Non-Network Benefits**

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

**Policy Deductible**

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

**Benefit Description**

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

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

**Routine Vision Examination**

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the Insured sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

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

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
**Eyeglass Lenses** - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations. The following Optional Lens Extras are covered in full.

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

**Contact Lenses** - Lenses worn on the surface of the eye to correct visual acuity limitations. Benefits include the fitting/evaluation fees and contacts.

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

**Necessary Contact Lenses** - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

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

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

This benefit includes:

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

### Schedule of Benefits

<table>
<thead>
<tr>
<th>Vision Care Service</th>
<th>Frequency of Service</th>
<th>Network Benefit</th>
<th>Non-Network Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Vision Examination or Refraction only in lieu of a complete exam.</td>
<td>Once per year.</td>
<td>100% after a Copayment of $20.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Once per year.</td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Bifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Trifocal</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>Lenticular</td>
<td></td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td><strong>Lens Extras</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polycarbonate Lenses</td>
<td>Once per year.</td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Standard scratch-resistant coating</td>
<td></td>
<td>100%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Oversized Lenses</td>
<td></td>
<td>20%</td>
<td>100% of the billed charge.</td>
</tr>
<tr>
<td>Vision Care Service</td>
<td>Frequency of Service</td>
<td>Network Benefit</td>
<td>Non-Network Benefit</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------</td>
<td>----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Eyeglass Frames</td>
<td>Once per year.</td>
<td>100%</td>
<td>50% of the billed charge.</td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost up to $130.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $130 - 160.</td>
<td>100% after a Copayment of $15.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $160 - 200.</td>
<td>100% after a Copayment of $30.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost of $200 - 250.</td>
<td>100% after a Copayment of $50.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>• Eyeglass frames with a retail cost greater than $250.</td>
<td>60%</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Limited to a 12 month supply.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Covered Contact Lens Selection</td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>• Necessary Contact Lenses</td>
<td>100% after a Copayment of $40.</td>
<td>50% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>Low Vision Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.</td>
<td>Once every 24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low Vision Testing</td>
<td>100% of the billed charge.</td>
<td>75% of the billed charge.</td>
<td></td>
</tr>
<tr>
<td>• Low Vision Therapy</td>
<td>100% of the billed charge.</td>
<td>75% of the billed charge.</td>
<td></td>
</tr>
</tbody>
</table>

**Section 2: Pediatric Vision Exclusions**

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

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

**Section 3: Claims for Pediatric Vision Care Services**

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

**Reimbursement for Vision Care Services**

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

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.
Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

Reimbursement for Low Vision Services
To file a claim for reimbursement for Low Vision Services, the Insured Person must provide all of the following information [on a claim form acceptable to the Company] at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

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

By facsimile (fax):

248-733-6060

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

Section 4: Defined Terms for Pediatric Vision Care Services
The following definitions are in addition to the policy DEFINITIONS:

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

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the policy.

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

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

In the event of Injury or Sickness, students should:

1. Report to their Physician or Hospital.

2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (insured's insurance company ID number) and name of the policy under which the student is insured. A Company claim form is not required for filing a claim.

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

Submit all Claims or Inquiries to:

Student Resources (SPC) Ltd.
A UnitedHealth Group Company
P.O. Box 809025
Dallas, Texas 75380-9025
1-888-302-6182
or visit our website at www.uhcsr.com

The Plan is Underwritten by:
Student Resources (SPC) Ltd.

This Plan is Market Through:
PGH Global

Please keep this Brochure as a general summary of the insurance. The Master Policy contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy # 2016-202897-1.