

2011 - 2012

Student Injury and Sickness Insurance Plan
Designed Exclusively for Students Attending
Blair Academy in New Jersey

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 800-767-0700 or by visiting us at www.uhcsr.com.

Eligibility

All Domestic students registered for credit courses are eligible to enroll in this insurance Plan.

All International students registered for credit courses are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. The Company maintains its right to investigate 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.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 15, 2011. 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, whichever is later. The Master Policy terminates at 11:59 p.m., August 14, 2012. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Refunds of premiums are allowed only upon entry into the armed forces. This policy is a non-renewable one year term policy.

Extension of Benefits After Termination

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

UMR Care Management should be notified of all Hospital Confinements prior to admission.

1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATION: 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.

UMR Care Management 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.

Schedule of Medical Expense Benefits - Injury and Sickness

Up to \$250,000 Maximum Benefit (For each Injury or Sickness)

Paid as Specified Below

Usual & Customary Charges are based on data provided by FAIR Health, Inc. using the 90th percentile based on location of provider.

Benefits will be paid for 100% of Covered Medical Expenses incurred up to \$7,500. After the Company has paid \$7,500, benefits will be paid for 80% of additional Covered Medical Expenses not to exceed \$50,000. After the Company has paid \$50,000, benefits will be paid for 100% of additional Covered Medical Expenses incurred not to exceed the \$250,000 Maximum Benefit for each Injury or Sickness.

Benefits will be paid up to the Maximum Benefit for each service scheduled below. Covered Medical Expenses include:

max = maximum	U&C = Usual & Customary Charges
INPATIENT	
Room & Board Expense , daily semi-private room rate; general nursing care provided by the Hospital.	U&C
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.	U&C
Post Partum Care / Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth. 48 hours vaginal / 96 hours cesarean delivery.	See Benefits for Postpartum Care and Routine Newborn Care
Intensive Care	U&C
Physiotherapy	U&C
Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. 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.	U&C
Assistant Surgeon	30% of Surgery Allowance
Anesthetist , professional services in connection with inpatient surgery.	U&C
Registered Nurse's Services , private duty nursing care.	U&C
Physician's Visits , benefits are limited to one visit per day and do not apply when related to surgery.	U&C
Pre-Admission Testing , payable within 7 working days prior to admission.	U&C
Psychotherapy , Benefits are limited to one visit per day.	Paid as any other Sickness
Biologically Based Mental Illness	See Benefits for Biologically Based Mental Illness

OUTPATIENT

Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. 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.	U&C
Day Surgery Miscellaneous , 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.	U&C
Assistant Surgeon	30% of Surgery Allowance
Anesthetist , professional services administered in connection with outpatient surgery.	U&C
Physician's Visits , benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	U&C
Physiotherapy , benefits are limited to one visit per day. <i>Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.</i>	U&C
Medical Emergency Expenses , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	U&C
Diagnostic X-ray & Laboratory Services	U&C
Radiation Therapy & Chemotherapy	U&C
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and Lab Procedures.	U&C
Injections , when administered in the Physician's office and charged on the Physician's statement.	U&C
Prescription Drugs , UnitedHealthcare Network Pharmacy, \$0 copay per prescription tier 1, tier 2, tier 3 / up to a 31 day supply per prescription. No Benefits outside of UnitedHealthcare Network Pharmacy.	\$1,500 max (Per Policy Year)
Psychotherapy , including all related or ancillary charges incurred as a result of a Mental & Nervous Disorder. Benefits are limited to one visit per day.	Paid as any other Sickness
Biologically Based Mental Illness	See Benefits for Biologically Based Mental Illness

OTHER

Ambulance Services	U&C
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	U&C
Alcoholism	See Benefits for Treatment of Alcoholism
Drug Abuse	No Benefits
Consultant Physician Fees , when requested and approved by the attending Physician.	U&C
Dental Treatment , made necessary by Injury to Sound, Natural Teeth.	U&C
Maternity	Paid as any other Sickness except as provided in the Benefits for Post Partum Care and Routine Newborn Care
Complications of Pregnancy	Paid as any other Sickness
Interscholastic Sports	Paid as any other Injury / \$75,000 max
Eating Disorders	U&C / \$5,000 max

Refer to brochure pages 7 to 14 for the following Mandated Benefits:

Benefits for Treatment of Alcoholism

Benefits for Biologically Based Mental Illness

Benefits for Diabetes Treatment

Benefits for Treatment of Inherited Metabolic Disease

Benefits for Inpatient Coverage for Mastectomies

Benefits for Reconstructive Breast Surgery

Benefits for Mammography

Benefits for Prostate Cancer Testing (PSA)

Benefits for Colorectal Cancer Screening

Benefits for Treatment of Wilm's Tumor

Benefits for Audiology and Speech Language Pathology

Benefits for Pap Smear

Benefits for Wellness Health Examinations and Counseling

Benefits for Home Health Care

Benefits for Anesthesia and Hospitalization for Dental Services

Benefits for Infertility Treatment

Benefits for Orthotic and Prosthetic Appliances

Benefits for Hearing Aids

Benefits for Prescription Female Contraceptives

Benefits for Postpartum Care and Routine Newborn Care

Benefits for Maternity Services

Benefits for Treatment of Autism and Other Developmental Disability

United Healthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable copayments. Your copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 877-417-7345 for the most up-to-date tier status.

\$0 copay per prescription or refill for tier 1 Prescription Drug up to 31 day supply.

\$0 copay per prescription or refill for tier 2 Prescription Drug up to 31 day supply.

\$0 copay per prescription or refill for tier 3 Prescription Drug up to 31 day supply.

Your maximum allowed benefit is \$1,500 (Per Policy Year).

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about network pharmacies, please call 877-417-7345.

Additional Exclusions

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

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. 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 and Benefits for Non-Standard Infant Formulas.

Definitions

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 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 1-877-417-7345.

Continuation of Coverage

If you have been continuously insured under the Policy for 3 months and due to your Total Disability are no longer eligible for coverage, you shall be entitled to continue coverage for yourself and your covered Dependents. This continued coverage shall terminate at the first to occur of the following: 1) the date you fail to make timely payment of premium; 2) the date you become eligible under another group plan providing similar benefits; 3) the date the Policy terminates. The premium rate for the continued coverage will be the same premium rate charged to other Insureds who are eligible for coverage under the Policy.

Maternity Testing

Benefits will be paid the same as any other Sickness for the following maternity routine tests and screening exams. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe; Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in any pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: AFP Blood Screening; Amniocentesis / AFP Screening; and Chromosome Testing. Fetal Stress / Non-Stress tests are payable. Pre-natal vitamins are not covered.

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

Mandated Benefits

Benefits for Treatment of Alcoholism

Benefits will be paid the same as any other Sickness for the treatment of Alcoholism when such treatment is prescribed by a Physician.

Outpatient treatment for alcoholism shall be paid to the same extent as inpatient treatment if it is provided: 1) at a Hospital or as aftercare at a detoxification facility; 2) by an alcoholism counselor certified by the State of New Jersey; and 3) under a program approved by the New Jersey Division of Alcoholism.

Only with respect to the Alcoholism Benefit, "Hospital" shall include 1) detoxification facilities licensed pursuant to P.L. 1975, C.305 of the laws of New Jersey; and 2) licensed, certified or state approved residential treatment facilities, when the Insured Person is under a program which meets the minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation.

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

Benefits for Hearing Aids

Benefits will be paid the same as any other Sickness for medically necessary Covered Medical Expenses incurred for the purchase of a hearing aid for an Insured Person 15 years of age or younger. Benefits include one hearing aid for each ear when prescribed or recommended by a licensed physician or audiologist.

Benefits are limited to \$1,000 per hearing aid for each hearing-impaired ear during a 24 month period.

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

Benefits for Maternity Services

Benefits will be provided for reimbursement in installments to obstetrical providers licensed in New Jersey who render services during the term of the Insured Person's pregnancy.

"Obstetrical provider licensed in New Jersey" means: (1) an obstetrician/gynecologist licensed by the State Board of Medical Examiners; or (2) a midwife licensed by the State Board of Medical Examiners as a certified midwife or a certified nurse midwife.

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

Benefits for Inpatient Coverage for Mastectomies

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

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

Benefits for Reconstructive Breast Surgery

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

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

Benefits for Prescription for Female Contraceptives

Benefits will be paid the same as any other Prescription Drug for Prescription Female Contraceptives.

"Prescription female contraceptives" means any drug or device used for contraception by a female, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in this State with a prescription written by a Physician licensed and authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms.

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

Benefits for Biologically Based Mental Illness

Benefits will be paid the same as any other Sickness for Biologically-Based Mental Illness.

"Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

Benefits will not be denied for services or supplies that are a Medical Necessity for the treatment of Insureds with Biologically Based Mental Illness, so long as such services or supplies are not experimental or investigational including but not limited to exclusions for:

- 1) Treatment of chronic conditions;
- 2) Physical, speech and occupational therapy that is non-restorative (does not restore previously possessed function, skill or ability);
- 3) Services rendered after a fixed period of time has elapsed from an Injury, procedure or the onset of Sickness;
- 4) Treatment of developmental disorders or developmental delay;
- 5) Therapy on a long-term basis;
- 6) Treatment of behavioral problems; and
- 7) Treatment of learning disabilities.

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

Benefits for Treatment of Inherited Metabolic Disease

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

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

"Low Protein Modified Food Product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein. "Medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a Physician.

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

Benefits for Diabetes Treatment

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

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

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

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

Benefits for Prostate Cancer Testing (PSA)

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

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

Benefits for Treatment of Wilm's Tumor

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

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

Benefits for Audiology and Speech Language Pathology

Benefits will be paid the same as any other Sickness for Audiology and Speech Language Pathology when such services are determined by a Physician to be medically necessary and are performed or rendered to the Insured by a licensed audiologist or speech language pathologist.

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

Benefits for Mammography

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

1. One baseline mammogram for women who are at least thirty-five but less than forty years of age;
2. One mammogram every year, or more frequently if recommended by a Physician, for women age forty and over.
3. In the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age intervals as deemed medically necessary by the woman's Physician.

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

Benefits for Colorectal Cancer Screening

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

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

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

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

- a. a screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, barium enema, or any combination thereof; or
- b. the most reliable, medically recognized screening test available.

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

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

Benefits for Pap Smear

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

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

Benefits for Post Partum Care and Routine Newborn Care

Benefits will be paid for the Usual and Customary Charges for expenses incurred for a mother and her newly born child in a Hospital for up to 48 hours following a vaginal delivery and 96 hours following a cesarean section.

Benefits shall be subject to all Deductible, copayment and coinsurance provisions of the policy.

Benefits for Infertility Treatment

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

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

Infertility means the disease or condition that results in the abnormal function of the reproductive system such that a person is not able to: impregnate another person; conceive after two years of unprotected intercourse if the female partner is under 35 years of age, or one year of unprotected intercourse if the female partner is 35 years of age or older or one of the partners is considered medically sterile; or carry a pregnancy to live birth.

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

Benefits payable for medications, including injectible infertility medications, will not be subject to any Policy exclusions for Prescription Drugs or injections.

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

Benefits for Anesthesia and Hospitalization for Dental Services

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

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

Benefits for Orthotic and Prosthetic Appliances

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

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

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

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

Benefits for Wellness Examinations and Counseling

Benefits will be paid the same as any other Sickness subject to the maximum benefits specified herein for each Insured Person for Covered Medical Expenses incurred in a health promotion program through Wellness Examinations and Counseling in which the program shall include, but not be limited to, the following tests and services:

1. For all Insured Persons 20 years of age or older:
 - a. Annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level; or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level; and
 - b. Annual consultation with a Physician to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.
2. For all Insured Persons 35 years of age or older, a glaucoma eye test every five years.
3. For all Insured Persons 40 years of age or older, an annual stool examination for presence of blood.
4. For all Insured Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years.
5. For all insured women 20 years of age or older, a pap smear as set forth in the Benefits for Pap Smear.
6. For all insured women 40 years of age or older, a mammogram as set forth in the Benefits for Mammography.
7. For all insured adults, recommended immunizations.

If a Physician or other health care provider recommends that it is a Medical Necessity to receive a different schedule of tests and services other than those specified above, the cost of these tests and services will not exceed the maximum amounts outlined below.

The cost of Wellness Examinations and Counseling tests and services provided in this benefit shall not exceed the following:

1. \$223 maximum per policy year for each Insured Person between the ages of 20 to 39 years, inclusive;
2. \$259 maximum per policy year for each insured male age 40 years and older; and
3. \$420 maximum per policy year for each insured female age 40 years and older.

For Insured Persons age 45 years or older, the cost of a left-sided colon examination will not be included in the amounts specified above; however, the cost will not exceed \$266 maximum per policy year.

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

Benefits for Home Health Care

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

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

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

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

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

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

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

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

Benefits for Treatment of Autism and Other Developmental Delays

Benefits will be paid the same as any other Sickness, except as indicated below, for screening and diagnosing autism or another developmental disability. When an Insured Person's primary diagnosis is autism or another developmental disability, the Company will provide benefits for Covered Medical Expenses incurred for Medically Necessary occupational therapy, physical therapy, and speech therapy, up to the number of days prescribed in the treatment plan by the Insured Person's Physician.

"Developmental disability" means a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or combination of mental or physical impairments; (2) is manifested before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more functional areas of life activity: self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living or economic self-sufficiency; and (5) reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina bifida, and other neurological impairments where the above criteria are met.

When the Insured Person's primary diagnosis is autism and the Insured Person is under age 21, the Company will provide coverage for Covered Medical Expenses incurred for Medically Necessary behavioral interventions. The interventions should be based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed in the treatment plan by the Insured Person's Physician.

Benefits shall also include any Covered Medical Expenses incurred by the Insured Person under an individualized family service plan through a family cost share.

Behavioral intervention treatment for an insured under the age of 21 shall be limited to \$36,000 per Policy Year.

Definitions

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

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

Covered Medical Expenses means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) 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 per policy year or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

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

FAIR Health, Inc. is a research and consulting firm that focuses on medical coding and reimbursement issues. The Company uses data received from FAIR Health, Inc. to determine Usual and Customary Charges.

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

Hospital Confined / Hospital Confinement means confined in a Hospital for at least 18 hours by reason of an Injury or Sickness for which benefits are payable.

Injury means bodily injury of an Insured Person: 1) caused by an accident which occurs while this policy is in force as to that Insured Person; 2) treated by a Physician within 90 days after the date of accident; and 3) which results directly and independently of all other causes in loss covered by this policy. 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.

Insured Person means the Named Insured. The term "Insured" also means Insured Person.

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

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in:

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

With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another Hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Medical Necessity means or describes a health care service that a Hospital or Physician, exercising prudent clinical judgment, would provide to an Insured Person for the purpose of evaluating, diagnosing or treating an Injury or Sickness or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Insured Person's Injury or Sickness; not primarily for the convenience of the Insured Person or the Physician; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Insured Person's Injury or Sickness.

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 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 Hospital Confinement.

Mental and Nervous Disorder means a Sickness that is a mental, emotional or behavioral disorder. Mental and nervous disorder does not mean a Biologically Based Mental Illness as defined in the Benefits for Biologically Based Mental Illness.

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

Newborn Infant means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for 31 days after birth on the same basis as any other Dependent children. Benefits for such a child will be for Injury or Sickness paid on the same basis as any other Sickness, including medically diagnosed congenital defects and birth abnormalities.

Other Valid and Collectible Group Insurance means: 1) any group plan, program or insurance policy; 2) any other group hospital, surgical or medical benefit plan; 3) union welfare plans; or 4) group employer or employee benefit programs.

Physician means: a duly qualified licensed Physician or any provider of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws, other than a member of the Insured's immediate family:

The term "member of the immediate family" means husband, wife, children, father, mother, brother, sister, and the corresponding in-laws.

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

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

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

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

Psychotherapy means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

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

Sickness means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition not separated by more than six months after a return to normal activity will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective date will be considered a Sickness under this policy.

Sound Natural Teeth means natural teeth, the major portion of which are present, regardless of fillings.

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

Usual and Customary Charges means 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. 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:

1. Acupuncture; allergy testing;
2. Addiction, excluding alcoholism addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3. Learning disabilities; except as specifically provided in Benefits for the Treatment of Autism and Other Developmental Delays or as otherwise provided in the policy;
4. Biofeedback;
5. Circumcision;
6. Congenital conditions; except as specifically provided for Newborn Infants including those continuously insured under the preceding student policy issued by this Company;
7. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn children including children continuously insured under the preceding student policy issued by this Company;
8. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
9. Elective Surgery or Elective Treatment;
10. Elective abortion;
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 disease process, except as specifically provided in the policy;
12. Foot care including: care of corns, bunions (except capsular or bone surgery), calluses;
13. Hearing examinations, except as specifically provided in the policy; or hearing aids; or other treatment for hearing defects and problems, except as specifically provided in the Benefits for Hearing Aids. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
14. Hirsutism; alopecia;
15. 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;
16. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
17. Loss sustained or contracted as a consequence of the Insured Person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a Physician.
18. Organ transplants; including organ donation;
19. Participation in a riot or civil disorder; Loss to which a contributing cause was the Insured Person's commission of or attempt to commit a felony or to which a contributing cause was the Insured Person's engagement in an illegal occupation;
20. 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, 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 expenses incurred in prescribing a drug for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in one of the following established reference compendia: (1) the American Medical Association Drug Evaluations; (2) the American Hospital Formulary Service Drug Information; (3) the United States Pharmacopoeia Drug Information; or it is recommended by a clinical study or review article in a major peer-reviewed professional journal. Any coverage of a drug shall also include Medically Necessary services associated with the administration of the drug;
 - d) Products used for cosmetic purposes, except as specifically provided in the Policy;
 - 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) Sexual enhancement drugs, such as Viagra;
 - h) Growth hormones; or
 - i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
21. Reproductive services including but not limited to: family planning; fertility tests; including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures; except as specifically provided in the Benefits for Infertility Treatment;
 22. Services provided normally without charge;
 23. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof;
 24. 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;
 25. Sleep disorders;
 26. Suicide or attempted suicide while sane or insane; or intentionally self-inflicted Injury;
 27. Supplies, except as specifically provided in the policy;
 28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
 29. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
 31. War or any act of war, declared or undeclared: 1) While the Insured Person is serving in the armed forces of any country; 2) while the Insured Person is serving in any civilian non-combatant unit supporting or accompanying any armed forces of any country or international organization; or 3) while the Insured Person is not serving in any armed forces if the Injury or Sickness occurs outside the 50 states of the United States of America, the District of Columbia, or Canada. A pro-rata premium will be refunded upon request for such period not covered; and
 32. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, except as specifically provided in Benefits for Treatment of Inherited Metabolic Disease. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

Scholastic Emergency Services: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you are eligible for Scholastic Emergency Services (SES). The requirements to receive these services are as follows:

International Students: You are eligible to receive SES worldwide, except in your home country.

Domestic Students: You are eligible for SES when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. 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 SES services must be arranged and provided by SES, Inc.; any services not arranged by SES, Inc. will not be considered for payment.

Key Services include:

- * Medical Consultation, Evaluation and Referrals
- * Foreign Hospital Admission Guarantee
- * Emergency Medical Evacuation
- * Medically Supervised Repatriation
- * Emergency Counseling Services
- * Lost Luggage or Document Assistance
- * Care for Minor Children Left Unattended Due to a Medical Incident
- * Prescription Assistance
- * Critical Care Monitoring
- * Return of Mortal Remains
- * Transportation to Join Patient
- * Interpreter and Legal Referrals

Please visit your school's insurance coverage page at www.uhcsr.com for the SES Global Emergency Assistance Services brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

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

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached

SES 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 SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com for additional information, including limitations and exclusions pertaining to the SES program.

Resolution of Grievances

You, the Insured, will be notified in writing by us if a claim or any part of your claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent plan provision(s) on which the denial was based.

If you have a complaint about your claim denial, you may call our Customer Service telephone number 1-800-767-0700 for further explanation to informally resolve your complaint. If you are not satisfied with our explanation of why the claim was denied, you, your authorized representative or provider may request an internal review of the claim denial. The following is our grievance review process:

- 1) The Insured must request in writing a benefit review within 60 days after the date that you receive the notice denying your claim. This will be an informal reconsideration review process of your claim by a Claims Supervisor. The Insured may not attend this review.
- 2) A decision will be made by the Claims Supervisor, within 30 days after the receipt of your request for review or the date all information required from the Insured is received.
- 3) If the Claims Supervisor denies the claim submitted for review and you are not satisfied with the explanation for the decision, you may request a first-level grievance review. The Insured is not required to attend the first level review.

EXPEDITED REVIEW

An expedited review will be conducted for any claim that is denied on the basis that the service or procedure did not meet the Medical Necessity criteria set out in the Definitions section of the policy. An expedited review follows the same procedures as any other grievance review, but is accomplished in a shorter time period. These time periods are shown below under the First Level and Second Level Grievance Review sections.

FIRST LEVEL GRIEVANCE REVIEW

The first level grievance material must be submitted to us in writing by the Insured or his/her provider for consideration by the first level reviewers who shall be our employees other than those responsible for claims payment on a day-to-day basis. The first level grievance review shall be provided at no cost to the Insured or his/her provider.

- 1) A first level review written decision will be issued to the Insured and, if applicable, the Insured's provider, within 10 days (5 days for Expedited Review) of the receipt of the grievance. The person or persons reviewing the grievance shall not be the same person or persons who initially handled the matter that is the subject of the grievance and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review shall contain:
 - A) The names, titles, professional credentials, qualifications and licensure of the person or persons reviewing the grievance.
 - B) A statement of the reviewer's understanding of the grievance.
 - C) The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for the Insured to respond further to the Insurer's position.
 - D) A reference to the evidence or documentation used as the basis for the decision.
 - E) If the decision is adverse, a statement advising the Insured or provider of his or her right to request an external adverse decision review or second-level grievance review and a description of the procedure for submitting a second-level grievance.

SECOND LEVEL GRIEVANCE REVIEW

- 1) A second level grievance review is available through an independent party to the Insured or provider dissatisfied with the first level grievance review decision. The costs of a second level grievance review requested by a provider will be shared by the parties.
- 2) Within 10 days (5 days for Expedited Review) of the receipt of the request for the second level review, we will provide the following information to the Insured:
 - A) The name, address and telephone number of the grievance review coordinator.
 - B) A statement of the Insured's rights, including the right to:
 - 1) Request and receive from us all information relevant to the case;
 - 2) Present his/her case to the review panel;
 - 3) Submit supporting material prior to and at the review meeting;
 - 4) Ask questions of any member of the panel;
 - 5) Be assisted or represented by a person of the Insured's choosing, including a family member, employer representative or attorney.
- 3) We will convene a second-level grievance review panel for each request. The panel shall comprise persons who were not previously involved in any matter giving rise to the second-level grievance, are not our employees, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. All of the persons reviewing a second-level grievance involving a clinical issue shall be providers who have appropriate expertise, including at least one clinical peer. Provided, however, if we used a clinical peer on an appeal on a first-level grievance review panel then we may use one of our employees on the second-level grievance review panel in the same matter if the second-level grievance review panel comprises three or more persons.
- 4) The second level grievance review meeting will be held within 45 days (15 days for an Expedited Review) of receipt of the second level review request.
- 5) The Insured will receive at least 15 days (5 days for an Expedited Review) notice of the second level grievance review meeting date.
- 6) The Insured will have the right to full review without condition of his/her attendance at the meeting.
- 7) A written statement of the second level grievance review panel's decision shall be issued to the Insured within 30 business days (5 business days for an Expedited Review) after the review meeting. The decisions shall include:
 - A) The professional qualifications and licensure of the members of the review panel.
 - B) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts.
 - C) The review panel's recommendation to the Insurer and the rationale behind that recommendation.
 - D) A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
 - E) In the review of a clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
 - F) The rationale for the Insurer's decision if it differs from the review panel's recommendation.
 - G) A statement that the decision is the Insurer's final determination in the matter.
 - H) Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

The New Jersey Department of Banking and Insurance has established the Independent Health Care Appeals Program. The purpose of the appeals program is to provide an independent medical necessity or appropriateness of services review of final decisions by carriers to deny, reduce or terminate benefits in the event the final decision is contested by the Insured or any health care provider acting on behalf of the Insured but only with the Insured's consent. The appeal review shall not include any decisions regarding benefits not covered by the Insured's health benefit plan. The decisions rendered through the Independent Health Care Appeals Program (IHCAP) are binding.

An Insured or health care provider may apply to the Independent Health Care Appeals Program for a review of a decision to deny, reduce or terminate a benefit if the Insured has already completed our appeals process and the Insured contests the final decision by us. The Insured shall apply to the department within 60 days of the date the final decision was issued by us, in a manner determined by the commissioner.

As part of the application, the Insured or health care provider shall provide the department with:

- (1) The name and business address of the carrier;
- (2) A brief description of the Insured's medical condition for which benefits were denied, reduced or terminated;
- (3) A copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the benefit; and
- (4) A written consent to obtain any necessary medical records from the carrier and, in the case of a managed care plan, any other out-of-network physician the person may have consulted on the matter.

The Insured shall pay the department an application processing fee of \$25.00, except that the commissioner may reduce or waive the fee in the case of financial hardship. The health care provider acting on the Insured's behalf shall bear all costs associated with the appeal that are normally paid by the Insured.

Prior to receiving hospital services, an Insured or a person designated by the Insured may sign a consent form authorizing a health care provider acting on the Insured's behalf to appeal a determination by the Company to deny, reduce or terminate benefits. The consent is valid for all stages of the Company's informal and formal appeals process and the Independent Health Care Appeals Program. An Insured shall retain the right to revoke his consent at any time.

A health care provider shall provide notice to the Insured whenever the health care provider initiates an appeal of the Company's determination to deny, reduce or terminate a benefit or deny payment for a health care service based on a medical necessity determination made by the Company. The health care provider shall provide additional notice to the Insured each time the health care provider continues the appeal to the next stage of an appeals process, including any appeal to an independent utilization review organization.

The New Jersey Department of Banking and Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the New Jersey Department of Banking and Insurance, Office of Consumer Protection Services, Division of Insurance, 20 West State Street, 9th Floor, PO Box 329, Trenton, NJ 08625-0329 or by telephone at (609) 292-5316, ext. 17902. You may also contact Student Insurance in writing at Student Insurance, Attn: Claims Appeals, PO Box 809025, Dallas, TX 75380-9025 or by telephone at (800) 767-0700.

Handling Claims

Written notice of claim must be given to the Insurer within 30 days after the date of Injury or Sickness for a covered loss, or as soon as reasonably possible.

The Company will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If the claimant does not receive such forms within 15 days after the Company receives notice of any claim under the policy, the claimant will be deemed to have complied with the Proof of Loss requirements.

Written proof of loss must be given to the Insurer at P.O. Box 809025, Dallas, Texas 75380-9025 within 90 days after that loss. If it was not reasonably possible to give written proof in the time required, we will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible.

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

The claim payment will be made on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means following receipt by the Company of the required documentation or modification of an initial submission. The Company will notify the Insured or the Insured's representative and the provider of services within 30 days of the receipt of the claim: a) if the claim is incomplete including a statement as to what substantiating documentation is required for adjudication of the claim; b) if the claim contains incorrect information (including incorrect coding), including a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; c) if the Company disputes the amount of the claim, including a statement as to the basis for the dispute; and d) when the claim is being investigated for suspected fraud or referred to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety due to strong evidence of fraud.

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

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

As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to:

(1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

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

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources

P.O. Box 809025

Dallas, Texas 75380-9025

1-888-455-9402

customerservice@uhcsr.com

claims@uhcsr.com

Sales/Marketing Service:

UnitedHealthcare **Student**Resources

805 Executive Center Drive West, Suite 220

St. Petersburg, FL 33702

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

**This Certificate is based on Policies
2011-1792-1 and 2011-1792-4**