

This Plan is Underwritten by UnitedHealthcare Insurance Company
2009 - 2010
STUDENT INJURY AND SICKNESS INSURANCE PLAN
Designed Especially for Students of



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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public 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 800-505-4160.

Eligibility

All full-time undergraduate students taking 12 or more credit hours and graduate students or matriculated students taking 9 or more credit hours are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished.

All part-time students eligible to enroll in this Plan on a voluntary basis.

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.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse (husband, wife or Civil Union partner) and unmarried children under 30 years of age who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective August 2, 2009. 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 August 1, 2010. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student.

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

The Policy is a Non-Renewable One Year Term Policy.

Extension of Benefits After Termination

The coverage provided under this 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 follows provided the condition continues:

- 1) Under the Basic Plan, not to exceed 90 days after the Termination Date; or
- 2) Under the Major Medical Plan, not to exceed 12 months after the Termination Date.

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

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

Continuation of Coverage

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

Schedule of Basic Medical Expense Benefits

Up to \$2,500 Maximum Benefit (For Each Injury or Sickness)

The policy provides benefits for 100% of the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of \$2,500 for each Injury or Sickness. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

UnitedHealthcare Options PPO Network Physicians and Hospitals have agreed to accept special reimbursement rates for treatment rendered to Insureds; therefore, use of UnitedHealthcare Options PPO Network may result in lower out of pocket expenses. All benefits payable for Covered Medical Expenses are subject to the coinsurance and maximum benefits for each service specified below.

Usual and Customary Charges are based on data provided by Ingenix using the 90th percentile based on location of provider.

Benefits for Wellness Health Examinations and Counseling for Insured persons under 20 years of age is as specified in Benefit for Wellness Health Examinations and Counseling for Insured persons 20 years of age or older. Benefits will be paid as any other Sickness up to \$750 maximum Per Policy Year.

Covered Medical Expenses include:

U&C = Usual & Customary Charges

INPATIENT	INJURY	SICKNESS
Room and Board Expense , daily semi-private room rate; and general nursing care provided by the Hospital.	100% of U&C / \$500 maximum per day	100% of U&C / \$500 maximum per day
Hospital Miscellaneous Expense , 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.	100% of U&C / \$2,000 maximum (Per Injury)	100% of U&C / \$2,000 maximum (Per Sickness)
Physiotherapy	Paid under Hospital Miscellaneous Expenses	Paid under Hospital Miscellaneous Expenses
Post-Partum Care / Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth.	No Benefits	Paid as any other Sickness / 48 hours vaginal / 96 hours cesarean delivery - See Benefits for Postpartum Care and Routine Newborn Care]

INPATIENT	INJURY	SICKNESS
Surgeon's Fees , in accordance with data provided by Ingenix. \$2,000 maximum total combined Inpatient and Outpatient. 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.	100% of U&C / \$2,000 maximum (Per Injury)	100% of U&C / \$2,000 maximum (Per Sickness)
Assistant Surgeon	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist , professional services in connection with inpatient surgery.	30% of Surgery Allowance	30% of Surgery Allowance
Registered Nurse's Services , private duty nursing care.	100% of U&C / \$50 maximum per 24 hour period / \$750 maximum (per Injury)	100% of U&C / \$50 maximum per 24 hour period / \$750 maximum (per Sickness)
Physician's Visits , benefits are limited to one visit per day and do not apply when related to Surgery.	100% of U&C / \$100 per visit maximum / \$750 maximum (per Injury)	100% of U&C / \$100 per visit maximum / \$750 maximum (per Sickness)
Pre-Admission Testing , payable within 3 working days prior to admission.	Paid under Hospital Miscellaneous Expense	Paid under Hospital Miscellaneous Expense
Psychotherapy , benefits are limited to one visit per day.	No Benefits	100% of U&C / \$30 maximum per visit for psychiatric consultation / 10 visits maximum combined Inpatient and Outpatient
Biologically Based Mental Illness	No Benefits	See Benefits for Biologically Based Mental Illness
OUTPATIENT	INJURY	SICKNESS
Surgeon's Fees , in accordance with data provided by Ingenix. \$2,000 maximum total combined Inpatient and Outpatient. 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.	100% of U&C / \$2,000 maximum (per Injury)	100% of U&C / \$2,000 maximum (per Sickness)

OUTPATIENT	INJURY	SICKNESS
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 and based on the Outpatient Surgical Facility Charge Index.	100% of U&C / \$1,500 maximum (Per Injury)	100% of U&C / \$1,500 maximum (Per Sickness)
Assistant Surgeon	25% of Surgery Allowance	25% of Surgery Allowance
Anesthetist , professional services administered in connection with outpatient surgery.	30% of Surgery Allowance	30% of Surgery Allowance
Outpatient Miscellaneous Benefit , includes benefits designated as Paid under Outpatient Miscellaneous Benefits. (Benefits payable for removal of non-malignant growths when deemed a Medical Necessity)	100% of U&C / \$1,000 maximum (Per Injury)	100% of U&C / \$1,000 maximum (Per Sickness)
Physician's Visits , benefits limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of U&C / \$100 per visit maximum / \$1,000 maximum	100% of U&C / \$100 per visit maximum / \$1,000 maximum
Physiotherapy , benefits are limited to one visit per day.	100% of U&C / \$35 per visit maximum / \$150 maximum (Per Injury)	No Benefits
Medical Emergency Expenses , use of the emergency room and supplies. Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness.	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous
Diagnostic X-Ray and Laboratory Services	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous
Test & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-ray and lab procedures	Paid under Outpatient Miscellaneous	Paid under Outpatient Miscellaneous

OUTPATIENT	INJURY	SICKNESS
Radiation and Chemotherapy	No Benefits	Paid under Outpatient Miscellaneous
Prescription Drugs , United Healthcare Network Pharmacy (UHPS) Mail order Prescription Drugs through UHPS at 2.5 times the retail copay; \$7.50 copay per prescription for Tier 1, \$25 copay per prescription for Tier 2, up to a 90 day supply subject to the Prescription Drug maximum benefit.	\$3 copay per prescription for Tier 1 \$10 copay per prescription for Tier 2 / up to a 31-day supply per prescription \$500 maximum per Policy Year	\$3 copay per prescription for Tier 1 \$10 copay per prescription for Tier 2 / up to a 31-day supply per prescription \$500 maximum per Policy Year
Psychotherapy , includes all related or ancillary charges incurred as a result of a Mental or Nervous Disorder. Benefits are limited to one visit per day.	No Benefits	100% of U&C / \$30 maximum per visit for psychiatric consultation / 10 visits maximum combined Inpatient and Outpatient
Biologically Based Mental Illness	No Benefits	See Benefits for Biologically Based Mental Illness
OTHER	INJURY	SICKNESS
Ambulance Services	100% of U&C / \$250 maximum (Per Injury)	100% of U&C / \$250 maximum (Per Sickness)
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered. <i>(Benefits payable for wheelchair and crutches only.)</i>	100% of U&C	100% of U&C
Consultant Physician Fees , when requested and approved by the attending Physician.	100% of U&C / \$50 maximum (Per Injury)	100% of U&C / \$50 maximum
Dental Treatment , made necessary by Injury to Sound, Natural Teeth.	100% of U&C / \$1,000 maximum and for bridges, caps and crowns	Paid under Surgery for treatment of impacted wisdom teeth
Alcoholism	No Benefits	See Benefits for Treatment of Alcoholism
Drug Abuse	No Benefits	No Benefits

OTHER	INJURY	SICKNESS
Maternity	No Benefits	Paid as any other Sickness except as provided in the Benefits for Postpartum Care and Routine Newborn Care
Complications of Pregnancy	No Benefits	Paid as any other Sickness
Elective Abortion	No Benefits	100% of U&C / \$150 maximum Per Policy Year
Second Surgical Opinion	100% of U&C / \$50 maximum	100% of U&C / \$50 maximum
Intramural & Club Sports	Paid as any other Injury	No Benefits
<p>Refer to Certificate pages 9-15 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; 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 Prescription Female Contraceptives; Benefits for Lead Poisoning Screening, Newborn Hearing Loss, Childhood Immunizations; Benefits for non-Standard Infant Formulas; Benefits for Postpartum Care and Routine Newborn Care; and Benefits for Orthotics and Prosthetic Appliances.</p>		

Major Medical Benefit

Maximum Benefit **\$47,500 For each Injury or Sickness**

Coinsurance **80%**

Deductible **- 0 -**

The Major Medical Benefit begins payment after the Basic Maximum Benefit of \$2,500 has been paid by the Company.

The Company will pay 80% for additional Covered Medical Expenses incurred up to Major Medical Maximum of \$47,500. The total benefit payable under Major Medical is \$50,000 minus the Basic Benefits already paid.

Additional Exclusions: No benefits will be paid under Major Medical for:

1. Room and Board expenses which exceed the semi-private room rate;
2. Psychotherapy; and
3. Services designated as “No Benefits” under the Basic Medical Expense Benefits Schedule of Benefits.

Pre-Admission Notification

Avidyn 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.

Avidyn 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.

UnitedHealthcare 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 or coinsurance. 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.firststudent.com or the customer service number on your ID card for the most up-to-date tier status.

\$3 copay per prescription order or refill for a Tier 1 Prescription Drug up to 31 day supply.

\$10 copay per prescription order or refill for a Tier 2 Prescription Drug up to 31 day supply.

Mail order Prescription Drugs are available at 2.5 times the retail copay up to a 90 day supply.

Your maximum allowed benefit is \$500.

Specialty Prescription Drugs – if you require Specialty Prescription Drugs, we may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Specialty Pharmacy, you will be responsible for the entire cost of the Prescription Drug. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the copayment or coinsurance that applies will reflect the number of days dispensed.

Designated Specialty Pharmacies – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Specialty Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Specialty Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

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 mail-order prescriptions or network pharmacies, please visit www.firststudent.com and log in to your online account or the customer service number on your ID card.

When prescriptions are filled at pharmacies outside the network, the Insured must pay for the prescriptions out-of-pocket and submit the receipts for reimbursement to UnitedHealthcare StudentResources, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

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-2.
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, except as required by state mandate.

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.

Benefits for 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; Amniocenteses / 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

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 Company will pay the applicable amount below. Payment under this benefit will not exceed the policy Maximum Benefit.

For Loss Of:

Life	\$ 1,000
Two or More Members	\$ 1,000
One Member	\$ 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.

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 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 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 dietitians 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 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 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 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 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 Prescription 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 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 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 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 injectable 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 Postpartum 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 Lead Poisoning, Newborn Hearing Loss and Childhood Immunizations

Benefits will be paid the same as any other Sickness, except that no Deductible will be applied, for the following services:

1. Screening by blood lead measurement for lead poisoning for eligible Dependent Children, including confirmatory blood testing as specified by the New Jersey Department of Health and Senior Services and including medical evaluation and any necessary medical follow-up or treatment for lead poisoned eligible Dependent Children.
2. Screening for Newborn Hearing Loss by appropriate electrophysiologic screening measures and periodic monitoring of eligible Dependent Infants for delayed onset hearing loss.
3. All childhood Immunizations as recommended by the Advisory on Immunization Practices of the United States Public Health Service and the New Jersey Department of Health and Senior Services.

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

Benefits for Wellness Health 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. \$750 maximum per policy year for each Insured Person between the ages of 20 to 39 years, inclusive;
2. \$750 maximum per policy year for each insured male age 40 years and older; and
3. \$750 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 \$750 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 Commissioner 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 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 Non-Standard Infant Formulas

Benefits will be paid the same as any other Prescription Drugs for the purchase of specialized non-standard infant formulas, when the insured infant’s Physician has diagnosed the infant as having multiple food protein intolerance and has determined such formula to be a Medical Necessity, and when the insured infant has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk. This benefit may be subject to utilization review, including periodic review, of the continued Medical Necessity of the specialized infant formula.

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.

Definitions

ADOPTED CHILD means the adopted child placed with an Insured while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Pre-existing Conditions limitation will not apply to an adoptive child. The Insured must notify the Company, in writing, of the adopted child not more than 30 days after placement or adoption.

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

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

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.

DEPENDENT means the spouse (husband, wife or Civil Union Partner) of the Named Insured, and dependent, unmarried children including any child for which the Named Insured is under court order to provide coverage. Children shall cease to be a Dependent on the first to occur of:

- 1) The end of the month in which they marry; or,
- 2) The end of the month in which they attain the age of thirty (30).

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

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

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually after the two-year period following the child's attainment of the limiting age. Termination will continue to be waived only while all of the above conditions are met and the Insured continues to be insured under this policy.

If the Named Insured's insurance under this policy terminates due to that person's death, insurance then in force on such Named Insured's Dependents will be continued for 180 days. This continuation of coverage is subject to the timely payment of premium due for the Insured Dependent's insurance and the policy provisions with respect to termination for reasons other than death of the Insured.

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

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities 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.

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

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

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

- 1) Progressive care;
- 2) Sub-acute intensive care;
- 3) Intermediate care units;
- 4) Private monitored rooms;
- 5) Observation units; 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 Sicknesses.

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. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

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 the first 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.

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

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; ultrasonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

PRE-EXISTING CONDITION means a condition which existed for which the Insured Person received treatment or medical advice from a Physician or used Prescription Drugs within 6 months prior to the Insured's Effective Date of the Coverage.

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 Pharmacopeia 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 of the Policyholder. 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. Acne; acupuncture; allergy, including allergy testing;
2. Learning disabilities;
3. Biofeedback;
4. Injections;
5. Circumcision;
6. Congenital conditions, except as specifically provided for Newborn or adopted 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 or adopted children including children continuously insured under the preceding student policy issued by this Company;
8. Dental treatment except as specifically provided in the Schedule of Benefits;
9. Elective Surgery or Elective Treatment;
10. 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;
11. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
12. Hearing examinations, except as specifically provided in the policy; or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
13. Hirsutism;
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 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;
17. Investigational services;
18. Organ transplants;
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. Pre-existing Conditions of Dependents, except for individuals who have been continuously Insured under the school's student insurance policy for at least 12 consecutive months; or, individuals who have been insured under another group policy immediately preceding the individual's Effective Date under this Policy. Credit shall be given to the Insured for satisfaction of the Pre-existing Condition waiting period under the prior policy, or any portion thereof if the prior waiting period has not been satisfied in full;
21. 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 Pharmacopeia 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.
22. 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;
 23. 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;
 24. 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;
 25. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;
 26. 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;
 27. Sleep disorders;
 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;
 30. 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;
 31. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia, 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 Assistance Services

Through participation in the New Jersey City University insurance plan, each Insured* is eligible for global emergency medical assistance services when traveling 100 miles or more from his/her permanent home or campus address or abroad. Services are accessible 24 hours a day, 365 days a year and are provided by Scholastic Emergency Services (SES)

What Makes the SES program unique?

1. Exceeds USIA requirements for International student and scholars
2. No maximums or subrogation for any assistance services Assist America provides
3. No pre-existing conditions or territorial exclusions
4. Worldwide network of pre-qualified medical providers
5. Operations Centers with immediate worldwide response capabilities
6. "Out of Area" medical problems alleviated

Key Services include:

Evacuation, Repatriation and Return of Mortal Remains:

Whenever appropriate medical facilities are not available locally, SES will utilize whatever mode of transport, equipment, and personnel is necessary to evacuate the participant to the **nearest** facility capable of providing appropriate care. Once the participant is ready to be released from the hospital, SES will arrange and pay to transport the participant to his/her residence or rehabilitation facility, with necessary medical supervision, if necessary.

If a participant should die while traveling, SES will render every possible assistance in the return of mortal remains including locating a funeral home to prepare the deceased for transport, procuring required documentation, providing the necessary shipping container as well as paying for transport.

Some additional services include:

- Medical Consultation, Evaluation and Medical Referrals
- Foreign Hospital Admission Guarantee
- Critical Care Monitoring
- Prescription Assistance
- Emergency Message Transmission
- Transport to Join Patient (when in-patient for more than 7 days)
- Care for Minor Children (left unattended due to medical incident)
- Emergency Trauma Counseling
- Lost Luggage or Document Assistance
- Legal and Interpreter Referrals

Please refer to www.firststudent.com for service descriptions.

To access services please call:

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

(609) 452-8570 Collect outside the United States

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. Claims for reimbursement of assistance services will not be accepted.

*Insured's spouse and dependent children may also be eligible for services.

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 1-800-505-4160 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.

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 mat-

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 First Student in writing at First Student, Attn: Claims Appeals, PO Box 809025, Dallas, TX 75380-9025 or by telephone at (800) 505-4160.

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.

A Company claim form is not required for filing a claim. Mail to the First Student at P.O. Box 809025, Dallas, Texas 75380-9025 all medical and Hospital bills along with the patient's name and Insured student's name, address, social security number and name of the Policyholder under which the student is Insured.

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

UNITED HEALTHCARE INSURANCE COMPANY

Submit all Claims Inquiries to:

First Student
P. O. Box 809025
Dallas, TX 75380-9025
1-800-505-4160
or visit our website at www.firststudent.com

Online Services:

Please visit our website at www.firststudent.com For Certificates, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services.

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the University 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 Policy #2009-200049-1

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