This Plan is Underwritten by UnitedHealthcare Insurance Company

2013 - 2014

Student Injury and Sickness Insurance Plan

Designed Especially for Students of

Felician College

Table of Contents

Limited Benefit Plan. Please Read Carefully.

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

This Certificate is subject to the Laws of the State of New Jersey

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $500,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-505-4160. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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 1-800-505-4160 or visiting us at www.firststudent.com.

Eligibility

All Undergraduate students taking 12 or more credit hours are required to purchase this insurance Plan, unless proof of comparable coverage is furnished.

All part time Undergraduate and Graduate students taking 6 or more credit hours, and all students who are enrolled in the ESL program are eligible to enroll in this insurance Plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the student actively attend classes.

The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse, (husband, wife or Civil Union partner) and Dependent children, including any child for which the Named Insured is under court order to provide coverage, up to 26 years of age. Dependent coverage may continue after age 26 under specific circumstances.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company or its authorized representative, whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2014. 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 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 12 months after the termination date.

However if an Insured is pregnant on the Termination Date and the conception occurred while covered under this policy, Covered Medical Expenses for such pregnancy will continue to be paid through the term of the pregnancy.

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

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

Pre-Admission Notification

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

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

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

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

Schedule of Medical Expense Benefits

Injury and Sickness

Up to $500,000 Maximum Benefit Paid As Specified Below
(Per Insured Person, Per Policy Year)

Deductible Preferred Provider: $200 (Per Insured Person) (Per Policy Year)
Deductible Out-of-Network: $500 (Per Insured Person) (Per Policy Year)

Coinsurance Preferred Provider: 70% except as noted below
Coinsurance Out-of-Network: 50% except as noted below

Out-of-Pocket Maximum Preferred Provider:
$5,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider:
$10,000 (For all Insureds in a Family, Per Policy Year)

Out-of-Pocket Maximum Out-of-Network:
$10,000 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network:
$20,000 (For all Insureds in a Family, Per Policy Year)

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

The Preferred Provider Deductible or Coinsurance will not apply to any preventive care benefits provided under the policy.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $500,000.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Policy includes both a Preferred Provider Coinsurance amount and a Preferred Provider Copayment amount, then the Preferred Provider Coinsurance amount will not be applied to those benefits that include a Preferred Provider Copayment amount. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. Covered Medical Expense incurred for services provided by an Out-of-Network Provider during a Hospital Confinement at a Preferred Provider Hospital will be paid at the Preferred Provider Copayment, Deductible, and/or Coinsurance level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

Student Health Center Benefits: The Deductible will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. Covered Medical Expenses include:

PA = Preferred Allowance	U&C = Usual & Customary Charges	
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Room and Board Expense, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	70% of PA	50% of U&C
Intensive Care	Paid under Room and Board Expense	
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.	70% of PA	50% of U&C
Routine Newborn Care, see Benefits for Postpartum Care and Routine Newborn Care.	Paid as any other Sickness	
Physiotherapy	70% of PA	50% of U&C
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	70% of PA	50% of U&C
Assistant Surgeon	70% of PA	50% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	70% of PA	50% of U&C
Registered Nurse's Services, private duty nursing care.	70% of PA	50% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	70% of PA	50% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	70% of PA	50% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	70% of PA	50% of 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.	70% of PA	50% of U&C
Assistant Surgeon	70% of PA	50% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	70% of PA	50% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	70% of PA	50% of U&C
Physiotherapy, Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. See also Benefits for Audiology and Speech Language Pathology and Benefits for Treatment of Autism or Other Developmental Disabilities	70% of PA	50% of U&C
Medical Emergency Expenses, including urgent care services in connection with a Medical Emergency. Benefits are payable for the facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	70% of PA / $200 Copay per visit	50% of U&C $200 Deductible per visit
Diagnostic X-ray Services	70% of PA	50% of U&C
Radiation Therapy	70% of PA	50% of U&C
Chemotherapy	70% of PA	50% of U&C
Laboratory Services	70% of PA	50% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	70% of PA	50% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	70% of PA	50% of U&C
Prescription Drugs, (Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90-day supply.)	UnitedHealthcare Pharmacy (UHCP) $15 Copay per prescription for Tier 1 $40 Copay per prescription for Tier 2 $75 Copay per prescription for Tier 3 up to a 31-day supply per prescription	No Benefits
OTHER		
Ambulance Services	70% of PA	70% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. *($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum are not included in the $500,000 Maximum Benefit)* See also Benefits for Orthotic and Prosthetic Appliances.	70% of PA	70% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	70% of PA	50% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *($1,000 maximum Per Policy Year) (Benefits are not subject to the $500,000 Maximum Benefit.)*	70% of U&C	70% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
Mental Illness Treatment, services received on an Inpatient and outpatient basis. See also Benefits for Biologically Based Mental Illness	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. See also Benefits for Treatment of Alcoholism	Paid as any other Sickness	
Maternity, see Benefits for Postpartum Care and Routine Newborn Care.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Preventive Care Services, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*; 2) immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.	100% of PA	No Benefits

OTHER	Preferred Providers	Out-of-Network Providers
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy. See Benefits for Reconstructive Breast Surgery.	Paid as any other Sickness	
Diabetes Services, in connection with the treatment of diabetes. See Benefits for Diabetes Treatment	Paid as any other Sickness	
Urgent Care Center, facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.	70% of PA $50 Copay per visit	50% of U&C $50 Deductible per visit
Home Health Care, see Benefits for Home Health Care.	Paid as any other Injury or Sickness	

Refer to Certificate pages 13 to 21 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 Screening
- 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 Non-Standard Infant Formulas
- Benefits for Lead Poisoning Screening, Newborn Hearing Loss and Childhood Immunizations
- Benefits for Postpartum Care and Routine Newborn Care
- Benefits for Treatment of Autism or Other Developmental Disabilities
- Benefits for Oral Chemotherapy Drugs
- Benefits for Treatment of Sickle Cell Anemia

Preferred Provider Information

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

UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-4160 and/or by asking the provider when making an appointment for services.

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

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

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

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-800-505-4160 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

Eligible outpatient Hospital expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits up to any limits specified in the Schedule of Benefits.

Professional & Other Expenses

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

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare 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.firststudent.com or call 1-855-828-7716 for the most up-to-date tier status.

$15 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

$40 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

$75 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

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

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 call 1-855-828-7716.

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, except as specifically provided in Benefits for Treatment of Inherited Metabolic Disease and Benefits for Non-Standard Infant Formula.

Definitions

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

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

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

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

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

Unproven Service(s) – means services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to absence of physician and health care provider specialty society recommendations and also insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Generic means a Prescription Drug Product that is Chemically Equivalent to a Brand-name drug.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

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

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

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

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

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

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 in addition to payment under the Medical Expense Benefits.

For Loss Of:

Life	$ 5,000
Two or More Members	$ 5,000
One Member	$ 2,500
Thumb or Index Finger	$ 1,250

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.

These benefits will be paid on a primary basis, in addition to the Insured's other insurance.

The termination of the policy or the Insured's coverage shall not prejudice the settlement of any claim for loss which occurred on or before the policy or the Insured's coverage terminates.

Maternity Testing

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

Initial screening at first visit:

- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
- Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

- Ultrasound (anatomy scan)
- Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS)

Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-505-4160.

Coordination of Benefits and Services

Purpose Of This Provision

An Insured may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this Policy as a Student and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows the Company to coordinate what the Company pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured is covered.

Definitions

The words shown below have special meanings when used in this provision. Please read these definitions carefully.

(1) **Allowable Expense:** The charge for any health care service, supply or other item of expense for which the Insured is liable when the health care service, supply or other item of expense is covered at least in part by any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this Policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense. The Company will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is a Medical Necessity. When this Policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, the Company will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

(2) **Claim Determination Period:** A Policy Year, or portion of a Policy Year, during which an Insured is covered by this Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

(3) **Plan:** Coverage with which coordination of benefits is allowed. Plan includes:

a) group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law; b) self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law; c) group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law; d) group hospital indemnity benefit amounts that exceed $150 per day; e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or nongovernmental plan.

Plan does not include:

a) individual or family insurance contracts or subscriber contracts; b) individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans; c) group or group-type coverage where the cost of coverage is paid solely by the Insured except when coverage is being continued pursuant to a Federal or State continuation law; d) group hospital indemnity benefit amounts of $150 per day or less; e) school accident-type coverage; f) a State plan under Medicaid.

(4) **Primary Plan:** The Plan whose benefits for an Insured's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "a" or "b" below exist:

a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or

b) All Plans which cover the Insured use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

(5) **Reasonable and Customary:** An amount that is not more than the usual or customary charge for the service or supply as determined by the Company, based on a standard which is most often charged for a given service by a provider within the same geographic area.

(6) **Secondary Plan:** The Plan which is not a Primary Plan. If an Insured is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple secondary plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this Coordination of Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

Primary And Secondary Plan

The Company considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. The Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the Procedures to be Followed by the Secondary Plan to Calculate Benefits section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services and supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

Rules For The Order Of Benefit Determination

(1) The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Insured as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

(2) The benefits of the Plan that covers the Insured as an employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers the Insured as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

(3) The benefits of the Plan that covers the Insured as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Insured under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

(4) If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the calendar year shall be determined before those of the parent whose birthday falls later in the calendar year.

b) If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

c) Birthday, as used above, refers only to month and day in a calendar year, not the year in which the parent was born.

d) If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

(5) If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a. The benefits of the Plan of the parent with custody of the child will pay first;

b. The benefits of the Plan of the spouse of the parent with the custody of the child will pay second; and

c. The benefits of the Plan of the parent without custody of the child will pay last.

d. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the primary plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:

(1) the basis on which the Primary Plan and the Secondary Plan pay benefits; and

(2) whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the Insured may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the Insured uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a capitation. This means that the health maintenance organization (HMO) pays the provider a fixed amount per Insured. The Insured is liable only for the applicable deductible, coinsurance or copayment. If the Insured uses the services of a non-network provider, the HMO will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and HMO refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The secondary plan shall pay the lesser of:

1) the difference between the amount of the billed charges and the amount paid by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

1) the difference between the amount of the billed charges for the Allowable Charges and the amount paid by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

The Insured shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the Insured has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the Insured be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

1) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or
2) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the Insured receives services or supplies from a provider who is in the network of both the Primary Plan and the secondary Plan, the Secondary Plan shall pay the lesser of:

1) the amount of any deductible, coinsurance or copayment required by the Primary Plan; or
2) the amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If the Insured receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The Insured shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Right to Receive and Release Needed Information – Certain facts are needed to apply these Coordination of Benefits and Services rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give the Company any facts it needs to pay the claim.

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

Right of Recovery – If the amount of the payments made by the Company is more than it should have paid under this provision, it may recover the excess from one or more of: a) the persons it has paid or for whom it has paid; b) insurance companies; or c) other organizations. The "amount of the payments made" includes the reasonable monetary value of any benefits provided in the form of services.

Automobile Related Injury Benefit Provision

(in association with the Coordination of Benefits provision)

Definitions

"**Automobile Related Injury**" means bodily injury sustained by an Insured Person as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile.

"**Allowable Expense**" means any medically necessary, reasonable, and customary item of expense, a part of which is covered by the policy or PIP at least in part as an Eligible Expense.

"**Eligible Expense**" means that portion of expense incurred for treatment of an Injury which is covered under the policy without application of any Deductible or coinsurance, if any.

"**Out-of-State Automobile Insurance Coverage (OSAIC)**" means any coverage for medical expenses under an automobile insurance policy other than PIP, as PIP is defined herein, including automobile insurance policies issued in another state or jurisdiction.

"**PIP**" means Personal Injury Protection coverage (specifically those provisions for medical expense coverage) provided as part of an automobile insurance policy issued in the state of New Jersey.

Application of Benefits

When Covered Medical Expenses are incurred as the result of an Automobile Related Injury, and the injured Insured Person has coverage under PIP or OSAIC, the following sections will be used to determine whether the policy provides coverage that is primary or secondary to auto coverage. These sections will be also be used to determine the amount payable if the policy provides primary or secondary coverage.

Determination of Primary or Secondary Coverage

The policy provides secondary coverage to PIP, unless health coverage has been elected as primary coverage by or for the Insured Person covered under the policy. This election is made by the Named Insured under a PIP policy and affects the Dependents of the Named Insured who are not themselves the Named Insured under another auto policy. The policy may be primary for one covered person, but not for another if the persons have separate auto policies and have made different selections regarding primacy of health coverage.

The policy is secondary to OSAIC. However, if the OSAIC contains provisions which make it secondary or excess to the Named Insured's Plan, then the Named Insured's Plan will be primary.

Effect on Benefits

If the Named Insured's Plan is primary to PIP or OSAIC, the policy will pay benefits on eligible expenses in accordance with the terms provided in the policy.

If the Named Insured's Plan is one of several insurance plans which provide benefits to the Insured and are primary to automobile insurance coverage, then the rules as provided in the Coordination of Benefits provision endorsement shall apply.

If the Named Insured's Plan is secondary to PIP or OSAIC, the benefits payable will be the lesser of: 1) the remaining uncovered allowable expenses after PIP has provided coverage after application of any Deductible or coinsurance; or 2) the actual benefits that would have been payable had the Named Insured's Plan been providing coverage primary to PIP.

To the extent that the policy provides coverage that supplements coverage under Medicare, then the Named Insured's Plan can be primary to auto insurance only insofar as Medicare is primary to auto insurance.

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 medically necessary 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 Oral Chemotherapy Drugs

If Prescription Drugs are covered in the Policy, benefits will be paid the same as any other Prescription Drug for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations, or any other provisions of the policy; provided that the Copayment, Coinsurance, and Deductibles are at least as favorable to an Insured Person as the Copays, Coinsurance or Deductibles that apply to intravenous or injected anticancer medications.

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 a Medical Necessity 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 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 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 Prostate Cancer Screening

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 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 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 a Medical Necessity 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 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 Wellness Health Examinations and Counseling

Benefits will be paid the same as any other Sickness 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 medically necessary 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.

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 the 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 the 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 the 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 the 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 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 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 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 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 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 medically necessary, 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 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 Postpartum Care and Routine Newborn Care

Benefits will be paid the same as any other Sickness for expenses incurred for a mother and her newly born child in a Hospital for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section.

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 Disabilities

Benefits will be paid the same as any other Sickness 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. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

"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 intellectual disability, 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.

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

Benefits for Treatment of Sickle Cell Anemia

Benefits will be paid the same as any other Sickness for medically necessary Covered Medical Expenses incurred for the treatment of sickle cell anemia.

If Prescription Drugs are covered in the Policy, benefits will be paid the same as any other Prescription Drug for medications prescribed for the treatment of sickle cell anemia,

Benefits shall be subject to all 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 the policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted 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.

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

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.

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

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

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CUSTODIAL CARE means services that are any of the following:

1) Non-health related services, such as assistance in activities.
2) Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3) Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

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

DEPENDENT means the spouse (husband, wife, or Civil Union partner) of the Named Insured and dependent children, including any child for which the Named Insured is under court order to provide coverage. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

A dependent will be eligible to continue coverage after age 26, up to the dependent's 31st birthday, if the dependent meets all of the following:

1) Resides in New Jersey; or if not a resident, is a full-time student at an accredited public or private institution of higher education.
2) Has evidence of creditable coverage or receipt of benefits under a group health plan, a church plan, an individual health benefits plan, or Medicare.
3) Is not covered under another group health plan, church plan, individual health benefits plan, and is not entitled to Medicare as of the effective date of coverage.
4) Does not have any children.
5) Does not have a spouse, Civil Union partner, or Domestic Partner

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

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

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

If the Named Insured's insurance under the 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 for diagnosis and major surgery on the premises or on a pre-arranged basis; and 6) is not primarily a clinic, nursing, rest or convalescent home.

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

INJURY means bodily injury of an Insured Person which is all of the following:

1) caused by an accident which occurs while the policy is in force as to that Insured Person.
2) treated by a Physician within 30 days after the date of accident.
3) which results directly and independently of all other causes in loss covered by the policy.

Covered Medical Expenses incurred as a result of an injury that occurred prior to the policy's Effective Date will be considered a Sickness under the policy.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital, by reason of an Injury or Sickness for which benefits are payable under the 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.
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 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 would result in any of the following:

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.
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/MEDICALLY NECESSARY means or describes those health care services that a Hospital or Physician, exercising prudent clinical judgment, would provide to an Insured Person, which are all of the following:

1) For the purpose of evaluating, diagnosing, or treating a Sickness or Injury, or its symptoms.
2) Is provided in accordance with the generally accepted standards of medical practice.
3) Is clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Insured Person's Injury or Sickness..
4) Is not primarily for the convenience of the Insured Person or the Physician.
5) Is 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 confined as an Inpatient means that both:

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

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

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

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the 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 the 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 and 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 us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. All Covered Medical Expenses paid as Copayment, Coinsurance, and Deductible shall count toward the Out-of-Pocket Maximum. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

1) Copayments, Deductibles, and Coinsurance amounts specifically associated with Prescription Drug Benefits.
2) Expenses that are not Covered Medical Expenses.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

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

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

POLICY YEAR means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

PRESCRIPTION DRUGS mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs 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.

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 under the policy.

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 the 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 the policy's Effective Date will be considered a sickness under the policy.

SOUND, NATURAL TEETH means natural teeth, the major portion of which are present, regardless of fillings.

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

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.

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

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where services are rendered. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under the policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions and Limitations

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

1. Acupuncture;
2. Addiction, excluding alcohol addiction, such as: nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or intellectual disability, except as specifically provided in Benefits for Treatment of Autism and Other Developmental Disabilities or as otherwise provided in the policy;
4. Biofeedback;
5. Circumcision;
6. Congenital conditions, except as specifically provided in Benefits for Treatment of Sickle Cell Anemia, and 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. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
13. Flat foot conditions; supportive devices for the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
14. Health spa or similar facilities; strengthening programs;
15. Hearing examinations, except as specifically provided in the policy; hearing aids; or cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma and except as specifically provided in 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;
16. Hirsutism; alopecia;
17. Hypnosis;
18. 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;
19. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
20. 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;
21. Investigational services;
22. Lipectomy;
23. 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;
24. Pre-existing Conditions of Dependents, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 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 school policy, or any portion thereof if the prior waiting period has not been satisfied in full; This exclusion will not be applied to an Insured Person who is under age 19;
25. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
    b) Immunization agents, except as specifically provided in the policy, biological sera, blood or blood products administered on an outpatient basis;

c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, 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.

26. 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; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures; except as specifically provided in Benefits for Infertility Treatment;
27. 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;
28. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
29. Services provided normally without charge;
30. 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, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
31. 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;
32. Sleep disorders;
33. Naturopathic services;
34. Supplies, except as specifically provided in the policy;
35. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
36. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

37. 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
38. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

FrontierMEDEX: Global Emergency Services

If you are a student insured with this insurance plan, you and your insured spouse and minor child(ren) are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

International Students, insured spouse and insured minor child(ren): You are eligible to receive FrontierMEDEX services worldwide, except in your home country.

Domestic Students, insured spouse and insured minor child(ren): You are eligible for FrontierMEDEX services 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.

FrontierMEDEX 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 services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment.

Key Services include:

*Transfer of Insurance Information to Medical Providers
*Transfer of Medical Records
*Worldwide Medical and Dental Referrals
*Emergency Medical Evacuation
*Transportation to Join a Hospitalized Participant
*Replacement of Corrective Lenses and Medical Devices
*Hotel Arrangements for Convalescence
*Return of Dependent Children
*Legal Referrals
*Message Transmittals
*Monitoring of Treatment
*Medication, Vaccine and Blood Transfers
*Dispatch of Doctors/Specialists
*Facilitation of Hospital Admission Payments
*Transportation After Stabilization
*Emergency Travel Arrangements
*Continuous Updates to Family and Home Physician
*Replacement of Lost or Stolen Travel Documents
*Repatriation of Mortal Remains
*Transfer of Funds
*Translation Services

Please visit www.firststudent.com for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX 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 FrontierMEDEX ID Number as listed on your Medical ID Card;
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.

FrontierMEDEX 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 FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at www.firststudent.com for additional information, including limitations and exclusions.

Resolution of Grievance Notice Internal Appeal Process and Independent Health Care Appeal Process Related to Health Care Services

INTERNAL APPEAL PROCESS

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

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

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

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

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

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

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

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

1. For a Pre-service Claim review, the notice shall be made no later than 15 days after the Company's receipt of the grievance.
2. For a Post-service Claim review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.

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

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

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

Expedited Internal Review (EIR) of an Adverse Determination

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

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

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

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

At the same time an Insured Person or an Authorized Representative files an EIR request, the Insured Person or the Authorized Representative may file a request for an Independent Health Care Appeal if:

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

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

INDEPENDENT HEALTH CARE APPEAL

An Insured Person or Authorized Representative may submit a request for an Independent Health Care Appeal when the service in question:

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

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

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

After exhausting the Internal Appeal process, and after receiving notice of an Adverse Determination or Final Adverse Determination, an Insured Person or Authorized Representative has 4 months to request an Independent Health Care Appeal. The request for an Independent Health Care Appeal should be made in writing to the Commissioner on forms provided to the Insured Person at the completion of the Internal Review Process.

The request for an Independent Health Care Appeal should be accompanied by $25 filing fee, payable by check or money order to the New Jersey Department of Banking and Insurance. The fee shall be waived if a financial hardship exists. Financial hardship may be demonstrated by the Insured Person through evidence that one or more members of the household is receiving assistance or benefits under the Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance. The filing fees for any one Insured Person shall not exceed $75.00 per policy year.

Independent Health Care Appeal Process

The New Jersey Department of Banking and Insurance shall forward the appeal to an IURO.

Upon receipt of the appeal, the IURO shall conduct a preliminary review and accept the request if the appeal:

a. the individual was an Insured Person covered under the Policy at the time the service was requested or provided;

b. the Insured Person has provided all the information and forms required by the IURO and the Department to make a preliminary determination; and

c. the service in question reasonably appears to be a Covered Medical Expense under the Policy.

Immediately after completion of the preliminary review, the IURO shall notify the Insured Person and, if applicable, the Authorized Representative in writing whether the request has been accepted. If the request is not complete, the IURO's notice shall include the reason(s) why the request is incomplete.

The IURO shall also notify the Insured Person and, if applicable, the Authorized Representative of the right to submit additional written information to be considered in the IURO's review. The IURO shall provide the Company with copies of any such additional information within 1 business day after receipt.

The IURO shall complete its review in a manner consistent with New Jersey state requirements. The IURO's final decisions shall be provided to the Insured Person, the Company, the Authorized Representative (if any), and the Department. The IURO's determination shall be binding on the Company and the Insured Person, except to the extent that other remedies are available under State or Federal law. The Company shall provide benefits, pursuant to and consistent with the IURO's decision, without delay, regardless of whether the Company intends to seek judicial review.

Within 10 business days of receiving the IURO's decision, the Company shall submit a report describing how the Company will implement the IURO's decision. The report shall be provided to the Insured Person, the Authorized Representative (if any), the IURO, and the Department.

Where to Send Independent Health Care Appeal Requests

All types of Independent Health Care Appeal requests shall be submitted to the New Jersey Department of Banking and Insurance.

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

You may contact the New Jersey Department of Banking and Insurance at:

New Jersey Department of Banking and Insurance
Office of Managed Care
20 West State Street
P. O. Box 329
Trenton, NJ 08625
(800) 445-7467
(888) 393-1062 (appeals)
http://www.state.nj.us/dobi/consumer.htm
ombudsman@dobi.state.nj.us

Questions Regarding Appeal Rights

Contact Customer Service at 1-800-505-4160 with questions regarding the Insured Person's rights to an Internal Appeal and Independent Health Care Appeal.

Online Access to Account Information

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

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

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

ID Cards

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

UnitedHealth Allies

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

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day by dialing the number listed on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to their Physician or Hospital.
2) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address and name of the college or university under which the student is insured. A Company claim form is not required for filing a claim.
3) File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Underwritten by

UNITEDHEALTHCARE INSURANCE COMPANY

Submit all Claims or Inquiries to

First Student

P. O. Box 809025

Dallas, TX 75380-9025

1-800-505-4160

or visit our website at **www.firststudent.com**

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the College 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 # 2013-1674-1

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