

2011-2012 United Chinese Plan

STUDENT INJURY
AND SICKNESS
INSURANCE PLAN

Silver, Gold and Platinum Plans Included

Designed Especially for Students and Scholars and
Their Dependents In Cooperation With The

**New York Service Center For
Chinese Study Fellows, Inc.**

纽约中国留学服务中心

Notice: Benefits may vary by state or coverage may not be available. The Plan is not available to residents of Massachusetts, New Hampshire, New Jersey, New York, North Carolina, Oregon, Puerto Rico, Vermont and Washington.



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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-888-344-6017 or by visiting us at www.uhcsr.com.

Eligibility

International students, scholars, exchange program participants, participating in Optional Practical Training, internships, research and teaching, with a valid passport and all types of visas who have not applied for permanent residency in the U.S. are eligible to enroll in either the Silver Plan - 2011-1716-13, the Gold Plan 2011-1716-15 or the Platinum Plan 2011-1716-17.

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

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the resident spouse and resident unmarried children under 19 years of age or 23 years if a full-time student at an accredited institution of higher learning, who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student.

Choice of Plan

Each eligible student has a choice of one of the benefit Plans. The Platinum Plan 2011-1716-17 has the highest benefits and a higher premium than the Gold Plan 2011-1716-15 or the Silver Plan 2011-1716-13. . Make your selection carefully, you cannot upgrade or downgrade coverage after the initial purchase of the Plan for the policy year. Please be aware that if you choose to upgrade or downgrade coverage in any subsequent year, a new Pre-existing Condition exclusion and waiting period will apply.

Pre-Admission Notification

UMR Care Management 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 the notification of any admission due to Medical Emergency.

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

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

Premium Rates

2011-1716-13 Silver Plan

	Annual	9 Months	6 Months	3 Months	Monthly
Student or Scholar Under Age 25	\$ 397	\$ 306	\$ 204	\$102	\$34
Student or Scholar Age 25 to 29	\$ 586	\$ 441	\$ 294	\$147	\$49
Student or Scholar Age 30 & Over	\$ 788	\$ 594	\$ 396	\$198	\$66
Spouse Under Age 25	\$1962	\$1476	\$984	\$492	\$164
Spouse Age 25 to 29	\$2635	\$1980	\$1320	\$660	\$220
Spouse Age 30 & Over	\$2696	\$2025	\$1350	\$675	\$225
All Children	\$1671	\$1260	\$ 840	\$420	\$140

2011-1716-15 Gold Plan

	Annual	9 Months	6 Months	3 Months	Monthly
Student or Scholar Under Age 25	\$ 526	\$ 396	\$ 264	\$132	\$44
Student or Scholar Age 25 to 29	\$ 772	\$ 585	\$ 390	\$195	\$65
Student or Scholar Age 30 & Over	\$ 1141	\$ 864	\$ 576	\$288	\$96
Spouse Under Age 25	\$4188	\$3150	\$2100	\$1050	\$350
Spouse Age 25 to 29	\$5574	\$4185	\$2790	\$1395	\$465
Spouse Age 30 & Over	\$6267	\$4707	\$3138	\$1569	\$523
All Children	\$2470	\$1854	\$1236	\$618	\$206

2011-1716-17 Platinum Plan

	Annual	9 Months	6 Months	3 Months	Monthly
Student or Scholar Under Age 25	\$ 798	\$ 603	\$ 402	\$201	\$67
Student or Scholar Age 25 to 29	\$1185	\$ 891	\$ 594	\$297	\$99
Student or Scholar Age 30 & Over	\$1763	\$ 1323	\$ 882	\$441	\$147
Spouse Under Age 25	\$5133	\$3852	\$2568	\$1284	\$428
Spouse Age 25 to 29	\$6834	\$5130	\$3420	\$1710	\$570
Spouse Age 30 & Over	\$7685	\$5769	\$3846	\$1923	\$641
All Children	\$3658	\$2745	\$1830	\$915	\$305

Silver Plan 2011-1716-13
Schedule of Medical Expense Benefits

\$300,000 Maximum Lifetime Benefit

\$100,000 Maximum Benefit paid as specified below

(For Each Injury or Sickness)

Deductible Preferred Providers \$150 (For Each Injury or Sickness)

(\$450 maximum Deductible per Insured Person Per Policy Year)

Deductible Out of Network \$300 (For Each Injury or Sickness)

(\$900 maximum Deductible per Insured Person Per Policy Year)

Coinsurance Preferred Providers 80% except as noted below

Coinsurance Out of Network 60% except as noted below

The Policy provides benefits for the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the \$100,000 Maximum Benefit for each Injury or Sickness not to exceed a \$300,000 Maximum Lifetime Benefit.

The Preferred Providers for this plan are members of UnitedHealthcare Options PPO.

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

Student Health Center: Covered Medical Expenses provided at the SHC will be paid at the Preferred Provider level of benefits after a \$45 Deductible for each Injury or Sickness is met.

Choice of Plan: Please be aware that if you choose to upgrade or downgrade coverage in any subsequent year, a new Pre-existing Condition exclusion and waiting period will apply.

Deductible: Only one Deductible will apply if more than one insured family member is injured in the same accident or contracts the same contagious disease within 30 days. Each Insured Person will be eligible for the Maximum Benefit.

All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below. 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
Hospital Expense , daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C / \$2,000 aggregate maximum per day
Intensive Care	Paid under Hospital Expense	
Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth.	Paid as any other Sickness / 48 hours vaginal/96 hours cesarean maximum	

INPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy	Paid under Hospital Expense	
Surgeon's Fees , \$5,000 <i>maximum</i> , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist , professional services in connection with inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services , private duty nursing care.	80% of PA	60% of U&C
Physician's Visits , benefits do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing , payable within 3 working days prior to admission.	Paid under Hospital Expense	
Psychotherapy , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
OUTPATIENT		
Surgeon's Fees , \$5,000 <i>maximum</i> , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% 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.	80% of PA	60% of U&C / \$1,500 maximum
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist , professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Outpatient Miscellaneous Benefit , \$1,500 <i>maximum for each Injury or Sickness</i> . includes benefits designated as Paid under Outpatient Miscellaneous Benefit (OMB).	80% of PA	60% of U&C
Physician's Visits , benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of PA / \$40 copay per visit	60% of U&C/ \$40 Deductible per visit

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy , benefits are limited to one visit per day. See exclusion #13 for additional Physiotherapy limitations. <i>Review of medical necessity will be performed after 12 visits per Injury or Sickness.</i>	Paid under Physician's Visits	
Diagnostic X-ray and Laboratory Services	Paid under Outpatient Misc. Benefit	
Medical Emergency Expenses , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	Paid under Outpatient Misc. Benefit	
Injections , when administered in a Physician's office and charged on the Physician's statement.	Paid under Outpatient Misc. Benefit	
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	Paid under Outpatient Misc. Benefit	
Radiation Therapy and Chemotherapy	Paid under Outpatient Misc. Benefit	
Psychotherapy , including all related or ancillary charges incurred as a result of a Mental & Nervous Disorder. Benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
Prescription Drugs , (\$500 maximum Per Policy Year)	UnitedHealthcare Network Pharmacy (UHPS) \$20 copay per prescription for Tier 1 / \$35 copay per prescription for Tier 2 / \$50 copay per prescription for Tier 3 / up to a 31-day supply per prescription	\$20 Deductible per prescription for generic drugs/ \$35 Deductible per prescription for brand name/ up to a 31-day supply per prescription

OTHER	Preferred Providers	Out-of-Network Providers
Ambulance Services	80% of PA	60% of U&C
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	80% of PA	60% of U&C
Consultant Physician Fees , when requested and approved by the attending Physician.	80% of PA	60% of U&C
Dental Treatment , made necessary by Injury to Sound, Natural Teeth.	80% of U&C	80% of U&C
Maternity / Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	80% of PA	60% of U&C

Maximum Lifetime Benefit - Silver Plan 2011-1716-13

Amounts paid to the Insured under this policy, and under all prior years' policies for Injury or Sickness, will be considered payments accrued under the Maximum Lifetime Benefit. The Maximum Lifetime Benefit will not exceed an amount determined by subtracting from \$300,000 all amounts paid to the Insured under any student injury and sickness policy issued to the New York Service Center for Chinese Study Fellows, Inc. for Injury or Sickness.

Gold Plan 2011-1716-15 Schedule of Medical Expense Benefits

\$250,000 Maximum Lifetime Benefit

Deductible Preferred Providers \$75 (For Each Injury or Sickness)

(\$150 maximum Deductible per Insured Person Per Policy Year)

Deductible Out of Network \$350 (For Each Injury or Sickness)

(\$700 maximum Deductible per Insured Person Per Policy Year)

Coinsurance Preferred Providers 90% except as noted below

Coinsurance Out of Network 70% except as noted below

The Policy provides benefits for the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Lifetime Benefit of \$250,000.

The Preferred Providers for this plan are members of UnitedHealthcare Choice Plus.

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

Student Health Center: Covered Medical Expenses provided at the SHC will be paid at the Preferred Provider level of benefits after a \$25 Deductible for each Injury or Sickness is met.

Choice of Plan: Please be aware that if you choose to upgrade or downgrade coverage in any subsequent year, a new Pre-existing Condition exclusion and waiting period will apply.

Deductible: Only one Deductible will apply if more than one insured family member is injured in the same accident or contracts the same contagious disease within 30 days. Each Insured Person will be eligible for the Maximum Benefit.

All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below. 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
Hospital Expense , daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	90% of PA	70% of U&C
Intensive Care	Paid under Hospital Expense	
Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth.	Paid as any other Sickness / 48 hours vaginal/96 hours cesarean maximum	

INPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy	Paid under Hospital Expense	
Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	70% of U&C
Assistant Surgeon	90% of PA	70% of U&C
Anesthetist , professional services in connection with inpatient surgery.	90% of PA	70% of U&C
Registered Nurse's Services , private duty nursing care.	90% of PA	70% of U&C
Physician's Visits , benefits do not apply when related to surgery.	90% of PA	70% of U&C
Pre-Admission Testing , payable within 3 working days prior to admission.	Paid under Hospital Expense	
Psychotherapy , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
OUTPATIENT		
Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	70% 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.	90% of PA	70% of U&C
Assistant Surgeon	90% of PA	70% of U&C
Anesthetist , professional services administered in connection with outpatient surgery.	90% of PA	70% of U&C
Physician's Visits , benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of PA / \$25 copay per visit	70% of U&C / \$25 Deductible per visit

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy , benefits are limited to one visit per day. See exclusion #13 for additional Physiotherapy limitations. <i>Review of medical necessity will be performed after 12 visits per Injury or Sickness.</i>	Paid under Physician's Visits	
Diagnostic X-ray and Laboratory Services	100% of PA / \$25 copay per visit	70% of U&C / \$25 Deductible per visit / \$800 maximum (For each Injury or Sickness)
Medical Emergency Expenses , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. <i>The copay / Deductible will be waived if admitted.</i>	100% of PA / \$100 copay per visit	100% of U&C / \$100 Deductible per visit
Injections , when administered in a Physician's office and charged on the Physician's statement.	90% of PA	70% of U&C
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	90% of PA	70% of U&C
Radiation Therapy and Chemotherapy	90% of PA	70% of U&C
Psychotherapy , including all related or ancillary charges incurred as a result of a Mental & Nervous Disorder. Benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
Prescription Drugs	UnitedHealthcare Network Pharmacy (UHPS) \$15 copay per prescription for Tier 1 / \$30 copay per prescription for Tier 2 / \$50 copay per prescription for Tier 3 / up to a 31-day supply per prescription	\$15 Deductible per prescription for generic drugs/ \$30 Deductible per prescription for brand name/ up to a 31-day supply per prescription

OTHER	Preferred Providers	Out-of-Network Providers
Ambulance Services	90% of PA	70% of U&C
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	90% of PA	70% of U&C
Consultant Physician Fees , when requested and approved by the attending Physician.	90% of PA	70% of U&C
Dental Treatment , made necessary by Injury to Sound, Natural Teeth.	90% of U&C	90% of U&C
Maternity / Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	90% of PA	70% of U&C
Home Health Care , \$75 per day / 40 days maximum.	90% of PA	70% of U&C
High Cost Procedure , for outpatient procedures costing \$500 or more, including but not limited to C.A.T. Scan, Magnetic Resonance Imaging (MRI) and Laser Treatments.	90% of PA	70% of U&C

Maximum Lifetime Benefit - Gold Plan 2011-1716-15

Amounts paid to the Insured under this policy, and under all prior years' policies for Injury or Sickness, will be considered payments accrued under the Maximum Lifetime Benefit. The Maximum Lifetime Benefit will not exceed an amount determined by subtracting from \$250,000 all amounts paid to the Insured under any student injury and sickness policy issued to the New York Service Center for Chinese Study Fellows, Inc. for Injury or Sickness.

Platinum Plan 2011-1716-17

Schedule of Medical Expense Benefits

Maximum Lifetime Benefit \$500,000

Deductible Preferred Providers \$0 (Per Insured Person) (Per Policy Year)

Deductible Out of Network \$250 (Per Insured Person) (Per Policy Year)

Coinsurance Preferred Provider 100% except as noted below

Coinsurance Out of Network 80% except as noted below

The Policy provides benefits for the Usual and Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Lifetime Benefit of \$500,000.

The Preferred Providers for this plan are members of UnitedHealthcare Choice Plus.

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

Student Health Center: Covered Medical Expenses provided at the SHC will be paid at the Preferred Provider level of benefits.

Choice of Plan: Please be aware that if you choose to upgrade or downgrade coverage in any subsequent year, a new Pre-existing Condition exclusion and waiting period will apply.

Deductible: Only one Deductible will apply if more than one insured family member is injured in the same accident or contracts the same contagious disease within 30 days. Each Insured Person will be eligible for the Maximum Benefit.

All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below. 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
Hospital Expense , daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	100% of PA	80% of U&C
Intensive Care	Paid under Hospital Expense	
Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth.	Paid as any other Sickness / 48 hours vaginal/96 hours cesarean maximum	

INPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy	Paid under Hospital Expense	
Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	100% of PA	80% of U&C
Assistant Surgeon	100% of PA	80% of U&C
Anesthetist , professional services in connection with inpatient surgery.	100% of PA	80% of U&C
Registered Nurse's Services , private duty nursing care.	100% of PA	80% of U&C
Physician's Visits , benefits do not apply when related to surgery.	100% of PA	80% of U&C
Pre-Admission Testing , payable within 3 working days prior to admission.	Paid under Hospital Expense	
Psychotherapy , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
OUTPATIENT		
Surgeon's Fees , in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	100% of PA	80% 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.	100% of PA	80% of U&C
Assistant Surgeon	100% of PA	80% of U&C
Anesthetist , professional services administered in connection with outpatient surgery.	100% of PA	80% of U&C
Physician's Visits , benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of PA / \$20 copay per visit	80% of U&C / \$20 Deductible per visit

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Physiotherapy , benefits are limited to one visit per day. See exclusion #13 for additional Physiotherapy limitations. <i>Review of medical necessity will be performed after 12 visits per Injury or Sickness.</i>	Paid under Physician's Visits	
Diagnostic X-ray and Laboratory Services	100% of PA / \$20 copay per visit	80% of U&C / \$20 Deductible per visit / \$800 maximum (For each Injury or Sickness)
Medical Emergency Expenses , use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. <i>The copay / Deductible will be waived if admitted.</i>	100% of PA / \$50 copay per visit	100% of U&C / \$50 Deductible per visit
Injections , when administered in a Physician's office and charged on the Physician's statement.	100% of PA	80% of U&C
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	100% of PA	80% of U&C
Radiation Therapy and Chemotherapy	100% of PA	80% of U&C
Psychotherapy , including all related or ancillary charges incurred as a result of a Mental & Nervous Disorder. Benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency	
Prescription Drugs	UnitedHealthcare Network Pharmacy (UHPS) \$15 copay per prescription for Tier 1 / \$30 copay per prescription for Tier 2 / \$50 copay per prescription for Tier 3 / up to a 31-day supply per prescription	\$15 Deductible per prescription for generic drugs/ \$30 Deductible per prescription for brand name/ up to a 31-day supply per prescription
OTHER		
Ambulance Services	100% of PA	80% of U&C
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	100% of PA	80% of U&C
Consultant Physician Fees , when requested and approved by the attending Physician.	100% of PA	80% of U&C
Dental Treatment , made necessary by Injury to Sound, Natural Teeth.	100% of U&C	100% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
Maternity / Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	100% of PA	80% of U&C
Intercollegiate Sports, \$5,000 maximum per each Injury	Paid as any other Injury	
Home Health Care, \$75 per day / 40 days maximum.	100% of PA	80% of U&C
High Cost Procedure, for outpatient procedures costing \$500 or more, including but not limited to C.A.T. Scan, Magnetic Resonance Imaging (MRI) and Laser Treatments.	100% of PA	80% of U&C

Maximum Lifetime Benefit - Platinum Plan 2011-1716-17

Amounts paid to the Insured under this policy, and under all prior years' policies for any Injury or Sickness, will be considered payments accrued under the Maximum Lifetime Benefit. The Maximum Lifetime Benefit will not exceed an amount determined by subtracting from \$500,000 all amounts paid to the Insured under any student injury and sickness policy issued to the New York Service Center for Chinese Study Fellows, Inc. for any Injury or Sickness.

Exclusions and Limitations

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

1. 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;
2. 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;
3. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
4. Elective Surgery or Elective Treatment;
5. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
6. Foot care including: flat foot conditions, care of corns, calluses, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
7. Hearing examinations or hearing aids; or other treatment for hearing defects and problems except as specifically provided in the Benefits for Child Health Screening Services or except when due to an Injury. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;

8. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
9. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
10. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
11. Injury sustained while (a) participating in any interscholastic, 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; **(2011-1716-13 and 2011-1716-15 Only)**
12. Investigational services;
13. Outpatient Physiotherapy; except for a condition that required surgery or Hospital Confinement: 1) within the 30 days immediately preceding such Physiotherapy; or 2) within the 30 days immediately following the attending Physician's release for rehabilitation; or except as specifically provided under Benefits For Habilitative Services For The Treatment of Congenital or Genetic Birth Defects;
14. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
15. Pre-existing Conditions, except for individuals who have been continuously insured under NY Service Center for Chinese Fellow's student insurance policy (2011-1716-13) for at least 12 consecutive months; If an individual: (1) had coverage under a Previous Plan as defined below; and (2) that coverage was continuous to a date not more than 63 days prior to the person's Effective Date under this Policy, the time under the Previous Plan will be credited toward the 12 consecutive months needed to provide benefits for a Pre-existing Condition. A "Previous Plan" means any accident and health insurance policy or certificate, nonprofit hospital or medical service corporation, HMO, MEWA, or plan provided by another benefit arrangement, including a government plan or program providing health benefits or health care. It does not include a Medicare Supplement; **(2011-1716-13 Only)**
16. Pre-existing Conditions, except for individuals who have been continuously insured under NY Service Center for Chinese Fellow's student insurance policy (2011-1716-15) for at least 6 consecutive months; If an individual: (1) had coverage under a Previous Plan as defined below; and (2) that coverage was continuous to a date not more than 63 days prior to the person's Effective Date under this Policy, the time under the Previous Plan will be credited toward the 6 consecutive months needed to provide benefits for a Pre-existing Condition. A "Previous Plan" means any accident and health insurance policy or certificate, nonprofit hospital or medical service corporation, HMO, MEWA, or plan provided by another benefit arrangement, including a government plan or program providing health benefits or health care. It does not include a Medicare Supplement; **(2011-1716-15 Only)**
17. 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 under the Benefits for Diabetes);
 - b) Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use;
 - c) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - d) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - e) Products used for cosmetic purposes;
 - f) Drugs used to treat or cure baldness; anabolic steroids used for body building;

- g) Anorectics - drugs used for the purpose of weight control;
 - h) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - i) Growth hormones; or
 - j) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
18. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
 19. 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; except as specifically provided under "Benefits for Child Health Screening Services";
 20. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
 21. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
 22. Suicide or attempted suicide while sane or insane; or intentionally self-inflicted Injury; **(2011-1716-13 and 2011-1716-15 Only)**
 23. Supplies, except as specifically provided in the policy;
 24. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

Definitions

INJURY means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

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

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

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.

PRE-EXISTING CONDITION means any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 months immediately prior to the Insured's enrollment date under the policy. "Pre-existing condition" does not include pregnancy. **(2011-1716-13 and 2011-1716-15 Only)**

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Preferred Provider Information

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

Preferred Providers in the local school area are: **UnitedHealthcare Options PPO** (*Silver Plan 2011-1716-13*) and **UnitedHealthcare Choice Plus** (*Gold and Platinum Plan, 2011-1716-15/17*).

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 1-888-344-6017, visiting www.uhcsr.com/nyservicecenter and/or by asking the provider when making an appointment for services.

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

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

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

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

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call 1-888-344-6017 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by a Preferred Provider 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 Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and copayment 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 copayment/coinsurance. Your copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 1-877-417-7345 for the most up-to-date tier status.

Silver Plan 2011-1716-13

\$20 copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

\$35 copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

\$50 copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Your maximum allowed benefit is \$500 maximum Per Policy Year.

Gold Plan 2011-1716-15

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

\$30 copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

\$50 copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Platinum Plan 2011-1716-17

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

\$30 copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

\$50 copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Please present and use your ID card to the network pharmacy when the prescription is filled.

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.uhcsr.com and log in to your online account or call 877-417-7345.

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

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

Definitions:

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

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call 1-877-417-7345.

Coordination of Benefits

Benefits will be coordinated with any other group medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

Accidental Death and Dismemberment Benefit

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Company will pay the applicable amount below. Payment under this benefit will not exceed the policy Maximum Benefit.

For Loss Of:

Life	\$15,000
Two or More Members	\$ 7,500
One Member	\$ 3,000
Thumb or Index Finger	\$ 3,000

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.

Maternity Testing

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered 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; and 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); and **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 1-888-344-6017.

Mandated Benefits

Benefits for Mental and Nervous Disorder, Alcoholism and Drug Dependency

Benefits will be paid the same as any other Sickness for Mental and Nervous Disorder, Alcoholism and Drug Dependency subject to all terms and conditions of the policy and the following limitations.

Covered Medical Expenses will be limited to inpatient, residential, and outpatient services provided by a Hospital, nonhospital residential facility, outpatient treatment facility, Physician, psychologist or independent clinical social worker. Before an Insured may qualify to receive benefits under this benefit, a Physician, psychologist or independent clinical social worker must: 1) certify that the individual is suffering from drug abuse, alcohol abuse or a Mental and Nervous Disorder; 2) certify that the treatment is medically or psychologically necessary; and 3) prescribe appropriate treatment which may include referral to other treatment providers.

Covered Medical Expenses will be limited to coverage of treatment of clinically significant substance use disorders or mental illness identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association.

Benefits will be paid not to exceed a maximum of 12 days per policy year for the process whereby a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent from the body, while keeping the physiological risk to the patient at a minimum. Additional treatment for alcoholism and drug dependency will be provided not to exceed 60 days per policy year for inpatient or residential care, and for a maximum of 75% for the first 40 outpatient visits per policy year and a maximum rate of 60% for any outpatient visits thereafter for that policy year.

Benefits will be paid for the treatment of Mental and Nervous Disorders not to exceed a maximum of 60 days per policy year for inpatient or residential care, and for a maximum of 75% for the first 40 outpatient visits per policy year and a maximum rate of 60% for any outpatient visits thereafter for that policy year. The inpatient and outpatient benefits for Mental and Nervous Disorders will not exceed a maximum lifetime benefit of \$80,000 or one third of the maximum lifetime benefit for any other Sickness, whichever is greater.

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

Benefits for Child Health Screening Services

Benefits will be paid the same as any other Sickness for uniform age-appropriate health screening requirements including childhood immunizations, consistent with the standards and schedules of the American Academy of Pediatrics, for Insureds from birth to age 21 years in the District and services outside the state for Insureds with special needs.

For the purposes of this benefit, Insureds with special needs means Insureds: 1) With physical or mental, disabilities or illnesses who reside or receive care in other states, because the District of Columbia does not have the facilities, resources, or services to appropriately treat the Insured's physical or mental, disability or illness; and 2) Whose parents or legal guardians reside in the District of Columbia.

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

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

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

For the purposes of this benefit:

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

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

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

Benefits for Diabetes

Benefits will be paid the same as any other Sickness for the equipment, supplies, and other outpatient self-management training and education, including medical nutritional therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a Physician legally authorized to prescribe such item.

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

Benefits for Postpartum Care

Benefits will be paid the same as any other Sickness for inpatient postpartum treatment in accordance with the medical criteria outlined in the most current version of or an official update to the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians or the Standards for Obstetric-Gynecologic Services prepared by the American College of Obstetricians and Gynecologists, and such coverage must include an in-hospital stay of a minimum of 48 hours after a vaginal delivery, and 96 hours after a Caesarian delivery.

Benefits will be provided in all cases of early discharge for post-delivery care within the minimum time periods established above to be delivered in the Insured's home, or, in a Physician's office, as determined by the Physician in consultation with the Insured. The at-home post-delivery care shall be provided by a Physician which includes a registered professional nurse, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health, and shall include:

- 1) Parental education;
- 2) Assistance and training in breast or bottle feeding; and
- 3) Performance of any medically necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

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 for Insured Persons. The screening shall be in compliance with American Cancer Society colorectal cancer screening guidelines, as updated.

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

Benefits for Cytologic Screening and Mammographic Examinations

Benefits will be paid the same as any other Sickness for: 1) cervical cytologic screening for women upon certification by the attending Physician that the test is a Medical Necessity; and 2) a baseline mammogram and an annual screening mammogram for women. All such services must be in accordance with the standard practice of medicine. All benefits are subject to the terms and conditions of the policy exclusive of any Deductible and coinsurance provisions in the policy.

Benefits for Prostate Cancer Screening

Benefits will be paid the same as any other Sickness for Prostate Cancer Screening in accordance to the latest screening guidelines issued by the American Cancer Society.

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

Benefits for Voluntary HIV Screening Test During Emergency Room Visit

Benefits will be paid for the cost of a voluntary HIV screening test performed on an Insured while the Insured is receiving emergency medical services, other than HIV screening, at a hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Medical Emergency which caused the Insured to seek emergency services. Benefits shall include one emergency department HIV screening test; the cost of administering such test; all laboratory expenses to analyze the test; the cost of communicating to the Insured the results of the test and any applicable follow-up instructions for obtaining healthcare and supportive services. Benefits shall not be subject to any Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

HIV screening test shall mean the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

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

Scholastic Emergency Services, Inc.: Global Emergency Medical Assistance

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

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

SES includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, Inc.; any services not arranged by SES, Inc. will not be considered for payment.

Key Services include:

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

Please log into your online account www.uhcsr.com for additional information on SES Global Emergency Assistance Services, including service descriptions and program exclusions and limitations.

To access services please call:

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

(609) 452-8570 Collect outside the United States

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

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

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

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com/nyservicecenter for additional information, including limitations and exclusions pertaining to the SES program.

Collegiate Assistance Program

Insured participants have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the number indicated 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.

Effective and Termination Dates

The Master Policy on file at the New York Service Center for Chinese Study Fellows, Inc. becomes effective at 12:01 a.m., August 1, 2011. 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, 2012. 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.

The Policy is a Non-Renewable One Year Term Policy. Refunds of premiums are allowed only upon entry into the armed forces.

Extension of Benefits after Termination

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

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

If the Insured is also an Insured under the succeeding policy issued to the Policyholder; this "Extension of Benefits" provision will not apply.

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

Resolution of Grievances

Insured Persons, Providers or their representatives with questions or complaints may call the Customer Service Department at 888-344-6017. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

If you are dissatisfied with the resolution reached through the Company's internal grievance system regarding medical necessity, you may contact the Department of Health Care Finance as follows:

Attention: Appeals Examiner
Department of Health Care Finance
825 North Capitol Street, NE, Suite 4119
Washington, DC 20002
(202) 442-5979

If you are dissatisfied with the resolution reached through the Company's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

Commissioner
Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20002
(202) 727-8000

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, Explanation of Benefits, correspondence and coverage information via My Account at www.uhcsr.com/nyservicecenter. Insureds can also print a temporary ID card, request a replacement ID card and locate network providers from My Account.

If you don't already have an online account, simply select the "Create an Account" link from the home page at www.uhcsr.com/nyservicecenter. Follow the simple, onscreen directions to establish an online account in minutes. Note that you will need your 7-digit insurance ID number to create an online account. If you already have an online account, just log in from www.uhcsr.com/nyservicecenter to access your account information.

Claim Procedure

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service for treatment or when not in school, 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, student ID number or insurance ID number and name of the association 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:

UnitedHealthcare StudentResources

P.O. Box 809025

Dallas, Texas 75380-9025

1-888-344-6017

customerservice@uhcsr.com

claims@uhcsr.com

Chinese Service Center Contact Information

1-800-226-1311

Please keep this brochure as a general summary of the insurance. The Master Policy on file at the New York Service Center for Chinese Study Fellows, Inc. contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. If any discrepancy exists between the brochure and the Policy, the Master Policy will govern and control the payment of benefits.

This Brochure is Based on Policy #'s

2011-1716-13 - Silver Plan, 2011-1716-15 - Gold Plan and

2011-1716-17 - Platinum Plan