2013-2014

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

ST. LAWRENCE UNIVERSITY™

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

Limited Benefit Plan. Please Read Carefully

Limited Benefits Health Insurance. The insurance evidenced by this certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, or major medical as defined by the New York State Insurance Department.

UnitedHealthcare®
A UnitedHealth Group Company

12-BR-NY

31-202712-1

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company of New York, 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 for each Injury or Sickness 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 1-800-767-0700. 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.

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public 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 non-public personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at www.uhcsr.com.

Eligibility

All full-time students are automatically enrolled in this insurance Plan at registration, unless proof of comparable coverage is furnished. Student coaches are required to purchase this insurance Plan. The Policyholder (St. Lawrence University) will pay student coach premiums as part of student coach salary stipends while they are registered and enrolled in classes.

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 that the Policy 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, same sex spouse) or Domestic Partner and dependent children under 26 years of age. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

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 10, 2013. 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., August 9, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 14 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

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.

Rates	Annual	Fall	Spring
Non-Athletes	8/10/13 - 8/9/14	8/10/13 - 1/14/14	1/15/14 - 8/09/14
Student	$1,351	$585	$769
Spouse	$1,973	$855	$1,123
Each Child	$1,973	$855	$1,123
Athletes			
Student	$1,678	$727	$955
Spouse	$1,973	$855	$1,123
Each Child	$1,973	$855	$1,123

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to certain non-insurer vendors or consultants by, or at the direction, of your school.

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.

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.

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

Maximum Benefit: $500,000 Paid As Specified Below
(For Each Injury or Sickness)
Deductible Preferred Provider: $100 (Per Insured Person) (Per Policy Year)
Deductible Out-of-Network: $200 (Per Insured Person) (Per Policy Year)
Coinsurance Preferred Provider: 100% except as noted below
Coinsurance Out-of-Network: 80% except as noted below
Out-of-Pocket Maximum Out-of-Network: $10,000
(Per Insured Person, Per Policy Year)

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

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

Out-of-Pocket Maximum Out-of-Network: 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. The policy Deductible, Copays and per service Deductibles, and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

Student Health Center Benefits: The Deductible will be waived when treatment is referred by the Student Health and Counseling Center. Preventive Care required to be covered under the Patient Protection Affordable Care Act and provided at the Student Health Center is covered at 100% with no Copay or Deductible.

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

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.	100% of PA	80% of U&C
Intensive Care	100% of PA	80% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
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
Routine Newborn Care, see Benefits for Maternity Expenses.	Paid as any other Sickness	
Physiotherapy	100% of PA	80% 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.	100% of PA	80% of U&C
Assistant Surgeon	100% of PA	80% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	25% of Surgery Allowance	
Registered Nurse's Services, private duty nursing care.	100% of PA	80% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. 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.	100% of PA	80% 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.	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

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Assistant Surgeon	100% of PA	80% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	25% of Surgery Allowance	
Physician's Visits, Benefits do not apply when related to surgery or Physiotherapy. Benefits include chiropractic care in connection with the detection or correction, by manual or mechanical means, of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Physician's Visits for preventive care are provided as specified under Preventive Care Services.	100% of PA / $15 Copay per visit	80% of U&C
Physiotherapy, All chiropractic care is payable under Physician's visits. 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.	100% of PA	80% of U&C
Medical Emergency Expenses, 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. (The Copay/per visit Deductible will be waived if admitted to the Hospital)	100% of PA / $100 Copay per visit	100% of U&C / $100 Deductible per visit
Diagnostic X-ray Services	100% of PA / Not subject to the policy Deductible	80% of U&C
Radiation Therapy	100% of PA	80% of U&C
Chemotherapy	100% of PA	80% of U&C
Laboratory Services	100% of PA / Not subject to the policy Deductible	80% 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.	100% of PA	80% of U&C
Injections	No Benefits	
Prescription Drugs, Benefits for prescription eye drop medications will not be denied for refills based upon any restriction on the number of days before a refill may be obtained; provided that such refill shall, to the extent practicable, be limited in quantity so as not to exceed the remaining dosage initially approved for coverage. The pharmacist may contact the prescribing Physician to verify the prescription.	UnitedHealthcare Pharmacy (UHCP) $10 Copay per prescription Tier 1 $25 Copay per prescription for Tier 2, up to a 31-day supply per prescription If a retail UnitedHealthcare Pharmacy offers to accept a price that is comparable to that of mail order pharmacy, then up to a consecutive 90 day supply of a Prescription Drug Product at 2.5 times the Copay that applies to a 31 day supply per prescription (Mail order through UHCP at 2.5 times the retail Copay up to a 90 day supply.)	$10 Deductible per prescription for generic drugs $25 Deductible per prescription for brand name up to a 31-day supply per prescription

OTHER	Preferred Providers	Out-of-Network Providers
Ambulance Services	100% of PA	80% 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. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.	80% of PA	80% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	100% of PA	80% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *(Benefits are not subject to the $500,000 Maximum Benefit.)*	80% of PA	80% of U&C
Mental Illness Treatment, see Benefits for Mental Illness Treatment, Benefits for Biologically Based Mental Illness, and Benefits for Children with Serious Emotional Disturbances.	Paid as any other Sickness	
Substance Use Disorder Treatment, see Benefits for Chemical Dependence (Alcoholism/Drug Abuse).	Paid as any other Sickness	
Maternity, see Benefits for Maternity Expenses.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion	No Benefits	
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy or partial Mastectomy. See Benefits for Breast Cancer Treatment.	Paid as any other Sickness	
Diabetes Services, in connection with the treatment of diabetes. See Benefits for Diabetes Expense.	Paid as any other Sickness	

OTHER	Preferred Providers	Out-of-Network Providers
Preventive Care Services, includes only those 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

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. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider and In-Network 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 PROVIDER - Eligible Inpatient expenses at 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. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call 1-800-767-0700 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus and 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.uhcsr.com or call 1-877-417-7345 for the most up-to-date tier status.

$10 Copay per prescription order or refill for a Tier 1 Prescription Drug up to 31 day supply.

$25 Copay per prescription order or refill for a Tier 2 Prescription Drug up to 31 day supply.

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

Please present your ID card to the network pharmacy when the prescription is filled. If you do not present the card, you will need to pay 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 to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-2.
4. Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a prescription order or refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. 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, except as required by state mandate.

Definitions

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

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

Maternity Testing

This policy does not cover all routine, preventive, or screening examinations or testing. The policy will cover those Maternity tests as required by the Health Resources and Services Administration's comprehensive guidelines for women's preventive care and screening, as updated, when received from a Preferred Provider with no cost share as referenced in the Preventive Care Services Benefits listed in the Schedule.

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. (Additional Maternity Testing may be allowed if Medical Necessity is established based on medical records.)

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 1-800-767-0700.

Mandated Benefits

Benefits for Maternity Expenses

Benefits will be paid the same as any other Sickness for pregnancy. Benefits will include coverage for an Insured mother and newborn confined to a Hospital as a resident inpatient for childbirth, but, in no event, will benefits be less than:

1) 48 hours after a non-cesarean delivery; or
2) 96 hours after a cesarean section.

Benefits for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. The Company will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Physician.

Benefits will be paid for:

1) parent education;
2) assistance and training in breast or bottle feeding; and
3) the performance of any necessary maternal and newborn clinical assessments.

In the event the mother chooses an earlier discharge, at least one home visit will be available to the mother, and not subject to any Deductible, Coinsurance, or Copayments.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) shall be conducted within 24 hours following:

1) discharge from the Hospital; or
2) the mother's request; whichever is later.

Except for the one home visit after early discharge, all benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

If the Insured Person's insurance should expire, the policy will pay under this benefit providing conception occurred while the policy was in force.

Benefits for Treatment of Chemical Dependence (Alcoholism and Drug Abuse)

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependence and Chemical Abuse:

Outpatient benefits are limited to one visit per day and include at least 60 outpatient visits per Policy Year of which up to 20 may be for family members.

Benefits will be limited to facilities in New York state certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clinic or medically supervised ambulatory substance abuse programs and in other states to those which are accredited by the joint commission on accreditation of hospitals as alcoholism or Chemical Dependence treatment programs.

"Chemical abuse" means alcohol and substance abuse.

"Chemical dependence" means alcoholism and substance dependence.

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

Benefits for Diabetes Expenses

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of diabetes. Such equipment and supplies must be recommended or prescribed by a Physician. Covered Medical Expenses includes but are not limited to the following equipment and supplies:

(a) lancets and automatic lancing devices;

(b) glucose test strips;

(c) blood glucose monitors;

(d) blood glucose monitors for the visually impaired;

(e) control solutions used in blood glucose monitors;

(f) diabetes data management systems for management of blood glucose;

(g) urine testing products for glucose and ketones;

(h) oral and injectible anti-diabetic agents used to reduce blood sugar levels;

(i) alcohol swabs, skin prep wipes and IV prep (for cleaning skin);

(j) syringes;

(k) injection aids including insulin drawing up devices for the visually impaired;

(l) cartridges for the visually impaired;

(m) disposable injectable insulin cartridges and pen cartridges;

(n) other disposable injectible medication cartridges and pen needles used for diabetes therapies;

(o) all insulin preparations;

(p) insulin pumps and equipment for the use of the pump (e.g. batteries, semi-permeable transparent dressings, insertion devices, insulin infusion sets, reservoirs, cartridges, clips, skin adhesie and skin adhesive remover, tools, specific to prescribed pump;;

(q) oral agents for treating hypoglycemia such as glucose tablets and gels; and

(r) glucagon emergency kits.

Benefits will also be paid for medically necessary diabetes self-management education and education relating to diet. Such education may be provided by a Physician or the Physician's staff as a part of an office visit. Such education when provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a Physician may be provided in a group setting. When medically necessary, self-management education and diet education shall also include home visits.

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

Benefits for Cervical Cytological Screening and Mammograms

Benefits will be paid the same as any other Sickness for cervical cytology screening and mammograms.

(a) Benefits will be paid for an annual cervical cytology screening for women (18) eighteen years of age and older. This benefit shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

(b) Benefits will be paid for mammograms as follows:

(1) Upon a Physician's recommendation, Insureds at any age who are at risk for breast cancer or who have a first degree relative with a prior history of breast cancer, and

(2) a single base line mammogram for Insureds age 35 but less than 40, and

(3) a mammogram every year for Insureds age 40 and older.

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 for Prescription Drugs for the Treatment of Cancer

If Prescription Drugs are covered in the Policy, benefits will be paid the same as any other Sickness for Prescription Drugs for the treatment of cancer provided that the drug has been recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

1. the American Hospital Formulary Service-Drug Information;
2. the national Comprehensive Cancer Networks Drugs and Biologics Compendium;
3. Thompson Micromedex Drugdex;
4. Elsevier Gold Standard's Clinical Pharmacology; or
5. other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS) or recommended by review article or editorial comment in a major peer reviewed professional journal.

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

Benefits for Medical Foods

If Prescription Drugs are covered in the Policy, benefits will be paid the same as any other Sickness for Prescription Drugs for the cost of enteral formulas for home use which are prescribed by a Physician as medically necessary for the treatment of specific diseases for which enteral formulas have been found to be an effective form of treatment. Specific diseases for which enteral formulas have been found to be an effective form of treatment include, but are not limited to inherited disease of amino-acid or organic metabolism; Crohn's disease; gastroesophagael reflux with failure to thrive, disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death.

Benefits will also be paid for the medically necessary Usual and Customary Charges for modified solid food products that are low protein or which contain modified protein for treatment of certain inherited diseases of amino acid and organic acid metabolism not to exceed a maximum benefit of $2,500 in any 12 month period.

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 adults and children diagnosed with Biologically Based Mental Illness.

"Biologically Based Mental Illness" means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such Biologically Based Mental Illnesses are defined as:

1. schizophrenia/psychotic disorders,
2. major depression,
3. bipolar disorder,
4. delusional disorders,
5. panic disorder,
6. obsessive compulsive disorder,
7. bulimia and anorexia.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or other provision of the Policy.

Benefits for Contraceptive Drugs or Devices

If Prescription Drugs are covered in the Policy, benefits will be paid the same as any other Prescription Drug for prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA) or generic equivalents approved as substitutes by the FDA.

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

Benefits for Prostate Screening

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer. Benefits shall include:

1. Standard diagnostic testing, including but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for an Insured with a prior history of prostate cancer;

2. An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for an Insured:

    a. age 50 and over who is asymptomatic; and

    b. age 40 and over who has 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 Autism Spectrum Disorder

Benefits will be paid the same as any other Sickness for the medically necessary screening, diagnosis and treatment of Autism Spectrum Disorder.

Benefits shall also include coverage for Applied Behavior Analysis up to a maximum benefit of $45,000.00 per Insured Person, per Policy Year. This maximum benefit will increase by the amount calculated from an increase in the medical component of the Consumer Price Index (CPI) as required by New York law.

"Autism Spectrum Disorder" means any pervasive developmental disorder as defined in the most recent edition of the diagnostic and statistical manual of mental disorders at the time services are rendered, including:

1. Autistic disorder;
2. Asperger's disorder;
3. Rett's disorder;
4. Childhood disintegrative disorder; or
5. Pervasive developmental disorder not otherwise specified (PDD-NOS).

"Applied Behavior Analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

"Behavioral Health Treatment" means counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functions of an Insured Person. Such Behavioral Health Treatment must be provided by a licensed provider. Benefits also include Applied Behavior Analysis, when provided or supervised by a behavior analyst certified pursuant to the behavior analyst certification board and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Department of Health and Education.

"Diagnosis of Autism Spectrum Disorder" means assessments, evaluations, or tests to diagnose whether an individual has Autism Spectrum Disorder.

"Pharmacy Care" means prescription drugs to treat Autism Spectrum Disorder that are prescribed by a provider legally authorized to prescribe under title eight of the education law, when prescription drugs are otherwise covered under this policy.

"Psychiatric Care" means direct or consultative services provided by a licensed psychiatrist.

"Psychological Care" means direct or consultative services provided by a licensed psychologist.

"Therapeutic Care" means services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the Insured Person, when such services are provided by licensed or certified speech therapists, occupational therapists, social workers, or physical therapists.

"Treatment of Autism Spectrum Disorder" shall include the following care and Assistive Communication Devices prescribed or ordered for an individual diagnosed with Autism Spectrum Disorder by a licensed Physician or licensed psychologist:

1. Behavioral Health Treatment;
2. Psychiatric Care;
3. Psychological Care;
4. Medical care provided by a licensed health care provider;
5. Therapeutic Care, including Therapeutic Care which is deemed habilitative or nonrestorative, in the event that the policy provides coverage for the Therapeutic Care; and
6. Pharmacy Care, in the event that the policy provides coverage for prescription drugs.

In connection with Assistive Communication Devices, benefits include a formal evaluation by a speech-language pathologist to determine the need for an Assistive Communication Device. Based on the formal evaluation, benefits will be provided for the rental or purchase of an Assistive Communication Device for an Insured Person who is unable to communicate through normal means (i.e., speech or writing) when the results of the formal evaluation indicate that an Assistive Communication Device is likely to provide the Insured Person with improved communication. The Company will determine whether the device should be purchased or rented.

Examples of Assistive Communication Devices include communication boards and speech-generating devices. Benefits are limited to dedicated devices that are not useful to an Insured Person in the absence of a communication impairment. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered. Benefits will be provided for the device most appropriate to the Insured Person's current functional level.

Benefits are not provided for item such as, but not limited to, laptops, desktops, or tablet computers. However, benefits are provided for software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device.

Coverage may be denied on the basis that such treatment is being provided to the Insured Person pursuant to an individualized education plan under article 89 of the education law. The provision of services pursuant to an individualized family service plan under section 2545 of the public health law, an individualized education plan under article 89 of the education law, or an individualized service plan pursuant to the regulations of the office for persons with developmental disabilities shall not affect coverage under the policy for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

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

Benefits for Second Medical Opinion for Diagnosis of Cancer

Benefits will be paid the same as any other Sickness for a second medical opinion by an appropriate Physician, including but not limited to a Physician affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

Benefits will be paid at the Preferred Provider level of benefits for a second medical opinion by a non-participating Physician, including but not limited to a Physician affiliated with a specialty care center for the treatment of cancer, when the attending Physician provides a written referral to a non-participating Physician. If the Insured receives a second medical opinion from a non-participating Physician without a written referral, benefits will be paid at the Out-of-Network level of benefits.

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

Benefits for End of Life Care for Terminally Ill Cancer Patients

Benefits will be paid the same as any other Sickness for Covered Medical Expenses for acute care services at Hospitals specializing in the treatment of terminally ill patients for those Insureds diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the Insured's attending Physician) if the Insured's attending Physician, in consultation with the medical director of the Hospital, determines that the Insured's care would appropriately be provided by the Hospital.

If the Company disagrees with the admission of or provision or continuation of care for the Insured at the Hospital, the Company will initiate an Expedited External Appeal. Until such decision is rendered, the admission of or provision or continuation of the care by the Hospital shall not be denied by the Company and the Company shall provide benefits and reimburse the Hospital for Covered Medical Expenses. The decision of the External Appeal Agent shall be binding on all parties. If the Company does not initiate an Expedited External Appeal, the Company shall reimburse the Hospital for Covered Medical Expenses.

The Company shall provide reimbursement at rates negotiated between the Company and the Hospital. In the absence of agreed upon rates, the Company will reimburse the Hospital's acute care rate under the Medicare program and shall reimburse for alternate level care days at seventy-five percent of the acute care rate. Payment by the Company shall be payment in full for the services provided to the Insured. The Hospital shall not charge or seek any reimbursement from, or have any recourse against an Insured for the services provided by the Hospital except for any applicable Deductible, copayment or coinsurance.

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

Benefits for Breast Cancer Treatment

Benefits will be paid the same as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured for a lymph node dissection, a lumpectomy or mastectomy or partial mastectomy for the treatment of breast cancer.

Breast reconstructive surgery after a mastectomy or partial mastectomy will also be paid as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured. Benefits will be paid for 1) all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and any physical complications of all stages of mastectomy, including lymphedemas.

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

Benefits for Bone Mineral Density Measurements or Tests

Benefits will be paid the same as any other Sickness for bone mineral density measurements or tests. If Prescription Drugs, and devices are covered in the Policy, then benefits will be paid for federally approved Prescription Drugs and devices.

Bone mineral density measurements or tests, drugs and devices shall include those covered under Medicare as well as those in accordance with the criteria of the national institutes of health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

Individuals qualifying for benefits shall at a minimum, include individuals:

(a) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(b) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(c) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(d) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(e) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

Benefits for Mental Illness Treatment

Benefits will be paid the same as any other Sickness for Mental Illness Treatment. Outpatient care shall be provided by a Physician or facility licensed by the commissioner of mental health or operated by the office of mental health.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or other provision of the Policy.

Benefits for Children with Serious Emotional Disturbances

Benefits will be paid the same as any other Sickness for Children with Serious Emotional Disturbances.

“Children with Serious Emotional Disturbances” means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and where there are one or more of the following:

1. serious suicidal symptoms or other life-threatening self-destructive behaviors;
2. significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
3. behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or
4. behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or other provision of the Policy.

Coordination of Benefits

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

Accidential Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 90 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

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

Definitions

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

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

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

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

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

DOMESTIC PARTNER means a person who is the Named Insured's sole spousal equivalent and is responsible with the Named Insured for each other's welfare. A domestic partner relationship must be demonstrated by 1) registration of the domestic partnership or signed affidavit; 2) proof of cohabitation; and 3) evidence of two or more of the following: a) a joint bank account, credit or charge card; b) joint obligation on a loan; c) status as authorized signatory on the partner's bank account, credit card or charge card; d) joint ownership or holding of investments; e) joint ownership of residence or ownership of real estate other than residence; f) listing of both partners as tenants on the lease of the shared residence; g) shared rental payments of residence; h) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; i) a common household and shared household expenses; j) shared household budget for purposes of receiving government benefits; k) status of one as representative payee for the other's government benefits; l) joint ownership of major items of personal property; m) joint ownership of a motor vehicle; n) joint responsibility for child care; o) shared child-care expenses; p) execution of wills naming each other as executor and/or beneficiary; q) designation as beneficiary under the other's life insurance policy or the other's retirement benefits account; r) mutual grant of durable power of attorney; s) mutual grant of authority to make health care decisions; t) affidavit by creditor or other individual able to testify to partners' financial interdependence; or u) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

ELECTIVE SURGERY OR ELECTIVE TREATMENT includes any surgery, service treatment, and/or supply which is deemed not to be a Medical Necessity for the treatment of a Sickness or Injury.

INJURY means bodily injury which is all of the following:

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

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

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

MEDICAL EMERGENCY means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in any of the following:

1) Placing the health of the Insured's or others in serious jeopardy.
2) Serious impairment of bodily functions.
3) Serious dysfunction of any body organ or part.
4) Serious disfigurement of the Insured.

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

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

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

The Medical Necessity of being Hospital Confined means that both:

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

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

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.

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

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

Exclusions and Limitations

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

1. Cosmetic procedures, except that cosmetic procedures does not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect. It also does not include breast reconstructive surgery after a mastectomy;
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;or due to congenital disease or anomaly;
4. Elective Surgery or Elective Treatment;
5. Elective abortion;
6. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses. Vision correction or other treatment for visual defects and problems; except when due to a covered Injury or disease process or a Medical Necessity;
7. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
8. Hearing examinations; hearing aids; or cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
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 mandatory automobile no-fault benefits;
11. Injury sustained while (a) participating in any interscholastic 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;
12. Investigational services or experimental treatment, except for experimental or investigational treatment approved by an External Appeal Agent in accordance with Insured Persons Right to an External Appeal. If the External Appeal Agent approves benefits of an experimental or investigational treatment that is part of a clinical trial, this policy will only cover the costs of services required to provide treatment to the Insured according to the design of the trial. The Company shall not be responsible for the cost of investigational drugs or devices, the costs of non-health care services, the cost of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial;
13. Commission of or attempt to commit a felony, or participation in a riot or insurrection;
14. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months. The Pre-existing Condition exclusionary period will be reduced by the total number of months that the Insured was covered under Creditable Coverage which was c continuous to a date not more than 63 days prior to the Insured's enrollment date under this policy. This exclusion will not be applied to an Insured Person who is under age 19;
15. Services provided normally without charge by the Health Service of the Policyholder;

16. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
17. Supplies, except as specifically provided in the policy;
18. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
19. Treatment, service or supply which is not a Medical Necessity, subject to Article 49 of N.Y. Insurance Law; and
20. 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).

Collegiate Assistance Program

Insured Students have access to nurse advice and health information and counseling support 24 hours a day by dialing the number of 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.

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.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create My Account Now" 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.

FrontierMEDEX: Global Emergency Services

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

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

Domestic Students, insured spouse/Domestic Partner 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.uhcsr.com/frontiermedex 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.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

Resolution Of Grievance Notice Internal Appeal Process and External Independent Review 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 Prospective Review, the notice shall be made no later than 30 days after the Company's receipt of the grievance.
2. For a Retrospective Review, the notice shall be made no later than 60 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 External Independent Review of the Final Adverse Determination pursuant to the State's External Review legislation;
6. Copies of the State's External Appeal Instructions and Application Form; and
7. The Insured Person's right to bring a civil action in a court of competent jurisdiction.
8. 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 Requests; and
2. related to a concurrent review Urgent Care Request 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 Request, 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:

1. An Expedited External Review (EER) request if 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. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the 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.

EXTERNAL INDEPENDENT REVIEW

If the Company makes an Adverse Determination or a Final Adverse Determination on the basis that the service is not a Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a Covered Medical Expense) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), an Insured Person or the Authorized Representative and, in connection with a Retrospective Adverse Determination, an Insured Person's Physician, may appeal that decision to an External Appeal Agent. An External Appeal Agent is an independent entity certified by New York State to conduct such appeals.

Insured Person's Right To Appeal A Determination That A Service Is Not A Medical Necessity

If an Adverse Benefit Determination or a Final Adverse Benefit Determination is made on the basis that the service is not a Medical Necessity, an Insured Person may appeal to an External Appeal Agent if the service, procedure or treatment must otherwise be a Covered Medical Expense under the policy and:

1. the Insured Person must have received a Final Adverse Determination through the Company's internal appeal process and the Company upheld the denial;
2. the Insured Person and the Company agreed in writing to waive any internal appeal;
3. the Insured Person applied for an Expedited External Appeal at the same time as an Expedited Internal Appeal; or
4. the Company fails to adhere to claim processing requirements.

Insured Person's Rights To Appeal A Determination That A Service Is Experimental Or Investigational

If an Adverse Benefit Determination or a Final Adverse Benefit Determination is made on the basis that the service is an experimental or investigational treatment, an Insured Person may appeal to an External Appeal Agent if the service must otherwise be a Covered Medical Expense under the Policy and:

1. the Insured Person must have received a Final Adverse Determination through the Company's internal appeal process and the Company must have upheld the denial;
2. the Insured Person and the Company must agree in writing to waive any internal appeal; or
3. the Insured person has been deemed to have exhausted or is not required to complete the internal appeal process.

In addition, the Insured Person's attending Physician must certify that the Insured Person has condition or disease for which:

1. standard health services or procedures have been ineffective or medically inappropriate;
2. there does not exist a more beneficial standard service or procedure covered by the Policy; or
3. there exists a clinical trial or rare disease treatment.

In addition, the Insured Person's attending Physician must have recommended either:

1. a service or procedure that, based on two documents from available medical and scientific evidence, is likely to be more beneficial to the Insured Person than any standard covered service or procedure; or
2. a clinical trial for which the Insured Person is eligible (only certain clinical trials can be considered); or
3. in the case of a rare disease, the Insured's Authorized Representative or attending Physician may present that the requested service or procedure is likely to benefit the Insured in the treatment of the rare disease and that such benefit outweighs

the risks associated with such service or treatment. In addition, the Insured Person's attending Physician must certify that the condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research network or that it affects fewer than 200,000 U.S. residents per year.

Any Physician certification provided under this section shall include a statement of the evidence relied upon by the Physician in certifying his recommendation.

For the purposes of this section, the Insured Person's attending Physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat the Insured Person's condition or disease. In addition, for a rare disease treatment, the attending Physician may not be the Insured Person's treating Physician.

Insured Person's Rights To Appeal A Determination That A Service Is Out-of-Network

If an Adverse Benefit Determination or a Final Adverse Benefit Determination is made on the basis that the Out-of-Network service is not materially different than the service available from a Preferred Provider, an Insured Person may appeal to an External Appeal Agent if the Insured Person satisfies three (3) of the following criteria:

1. The service must otherwise be a Covered Medical Expense under the Policy; and
2. The Insured Person must have requested pre-authorization for the Out-of-Network treatment; and
3. a. The Insured Person must have received a Final Adverse Determination through the Company's internal appeal process and the Company upheld the denial;
   b. The Insured Person and the Company agreed in writing to waive any internal appeal;
   c. The Insured Person applied for an Expedited External Appeal at the same time as an Expedited Internal Appeal; or
   d. The Company fails to adhere to claim processing requirements.

In addition, the Insured Person's attending Physician must certify that:

1. the Out-of-Network services is materially different from the alternate recommended service available from a Preferred Provider;
2. based on two(2) documents from available medical and scientific evidence, the Out-of-Network service is likely to be more clinically beneficial than the alternate recommended service available from a Preferred Provider; and
3. the adverse risk of the Out-of-Network service would likely not be substantially increased over the alternate recommended service available from a Preferred Provider.

For the purposes of this section, the Insured Person's attending Physician must be a licensed, board-certified or board eligible physician qualified to practice in the specialty area appropriate to treat the Insured Person for the requested Out-of-Network service.

The Insured Person does not have the right to an External Appeal for an Adverse Benefit Determination or a Final Adverse Benefit Determination related to a referral to an Out-of-Network Provider on the basis that a Preferred Provider is available to provide the particular service requested by the Insured Person.

The External Appeal Process

If, through the Company's Internal Appeal process, the Insured Person has received an Adverse Determination or a Final Adverse Determination upholding a denial of benefits on the basis that the service is not a Medical Necessity or is an experimental or investigational treatment, the Insured Person has 4 months from receipt of such notice to file a written request for an External Appeal. If the Insured Person and the Company have agreed in writing to waive any Internal Appeal, the Insured Person has 4 months from receipt of such waiver to file a written request for an External Appeal. If the Company fails to adhere to claim processing requirements, the Insured Person has 4 months from such failure to file a written request for an External Appeal. The Company will provide an External Appeal Application with the Adverse Determination or Final Adverse Determination issued through the Company's Internal Appeal process or its written waiver of an Internal Appeal.

The Insured Person may also request an External Appeal Application from the New York State Department of Financial Services at 1 (800) 400-8882. The completed External Appeal Application should be submitted to the New York State Department of Financial Services at the address indicated on the application. If the Insured Person or, where applicable, the Insured's Physician satisfies the criteria for an External Appeal, the New York State Department of Financial Services will forward the request to a certified External Appeal Agent.

The Insured Person and the Insured's Physician, where applicable, will have an opportunity to submit additional documentation with his request. If the External Appeal Agent determines that the information the Insured Person submits represents a material change from the information on which the Company based its denial, the External Appeal Agent will share this information with the Company in order for the Company to exercise its right to reconsider its decision. If the Company chooses to exercise this right, the Company will have three (3) business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), the Company does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Insured Person's completed application. The External Appeal Agent may request additional information from the Insured Person, the attending Physician or the Company. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the Insured Person, the attending Physician (if appropriate), and the Company in writing of its decision within two (2) business days.

If the Insured Person's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Insured Person's health, or if the attending Physician certifies that the standard External Appeal time frame would seriously jeopardize the Insured Persons's life, health or ability to regain maximum function; or if the Insured Person has received emergency services and has not been discharged from a facility and the denial concerns an admission, availability of care or continued stay, the Insured Person may request an Expedited External Appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must make a reasonable attempt to immediately notify the Insured Person, the attending Physician (where appropriate), and the Company by telephone or facsimile of that decision. The External Appeal Agent must also notify the Insured Person in writing of its decision.

If the External Appeal Agent overturns the Company's decision that a service is not a Medical Necessity or approves benefits for an experimental or investigational treatment, the Company will provide benefits subject to the other terms and conditions of this policy. Please note that if the External Appeal Agent approves benefits for an experimental or investigational treatment that is part of a clinical trial, the Policy will only cover the costs of services required to provide treatment to the Insured Person according to the design of the trial. The Company shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the Insured Person and the Company. The External Appeal Agent's decision is admissible in any court proceeding.

The Company will charge the Insured Person a fee of $25 per each External Appeal, not to exceed a total of $75 per Policy Year. The Company will waive the fee if the Company determines that paying the fee would pose a hardship to the Insured Person.

The Company will charge the Insured Person's attending Physician a fee of $50 per each External Appeal.

If the External Appeal Agent overturns the Adverse Determination or Final Adverse Determination, then the Company shall refund the fee.

Insured Person's and Insured Person's Physician's Responsibilities

The Insured Person or, as applicable, the Insured Person's Physician must initiate the External Appeal process. The External Appeal process may be initiated by filing the completed appropriate application with the New York State Department of Financial Services. The Insured Person may appoint an Authorized Representative to assist with the External Appeal request; however, the Department of Financial Services may contact the Insured Person to request written confirmation of the appointment. For Retrospective Adverse Determination appeals, the Insured Person must sign an acknowledgement of the request and sign a consent to release of medical records.

Under New York State law, the completed request for appeal must be filed within 4 months of either the date upon which written notification from the Company that it has upheld a denial of benefits is received or the date upon which written waiver of any internal appeal is received or the failure of the Company to adhere to claim processing requirements. The Company has no authority to grant an extension of this deadline.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

New York State Department of Financial Services
P. O. Box 7209
Albany, NY 12224-0209
(800) 400-8882
Email: externalappealquestions@dfs.ny.gov
Website: www.dfs.ny.gov

Questions Regarding Appeal Rights

Contact Customer Service at 800-767-0700 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

Community Service Society of New York
Community Health Advocates
105 East 22nd Street, 8th floor
New York, NY 10010
(888) 614-5400
Website: http://www.communityhealthadvocates.org/

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, social security number and name of the 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 120 days of service or as soon as reasonably possible.

The Plan is Underwritten by

UnitedHealthcare Insurance Company of New York

Submit all Claims or Inquiries to:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-767-0700
972-233-8200

Sales/Marketing Services

UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
727-563-3400

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

This Certificate is based on Policy # 2013-202712-1

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