2010-2011

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for the Students of

NSNA

FOR MASSACHUSETTS RESIDENTS ONLY
NON-RENEWABLE ONE YEAR TERM INSURANCE

THIS PLAN INCLUDES A PRE-EXISTING CONDITION EXCLUSION PROVISION.
PLEASE SEE PAGE 1 CHOICE OF PLAN AND PAGE 20 DEFINITION SECTION
FOR FURTHER INFORMATION.

UnitedHealthcare®
A UnitedHealth Group Company

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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 1-800-505-5450 or by visiting us at www.uhcsr.com.

Eligibility

All active and associate members of the National Student Nurses Association who are taking a minimum of 6 credit hours and sustaining members who are enrolled in graduate degree programs are eligible to enroll in either Plan I (*Low Option #240-11*) or Plan II (*High Option #240-12)* of this insurance Plan.

All Insured students may purchase Major Medical coverage on an optional basis.

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

Optional Coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment in the Plan. Only those students enrolled in Basic coverage my purchase Optional Major Medical coverage. Students may purchase optional coverages for themselves or themselves and all family members.

Choice of Plan

Each eligible student has a choice of one of the benefit plans. The benefits provided by each plan are based on the premium charged. Therefore, Plan II (*#240-12*) has the highest benefits and highest premium. Plan I (*#240-11*) has the lowest benefits and the lowest premium. Make your selection carefully, you cannot upgrade or downgrade coverage after the initial purchase of the plan for this policy year.

Please be aware that if you choose to upgrade your coverage in any subsequent policy year, the benefit levels above your previous plan's limits will be subject to a new pre-existing exclusion and waiting period. You will not be subject to a new pre-existing exclusion on the lower benefit levels.

Effective and Termination Dates

The Master Policy becomes effective September 1, 2010. 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 December 1, 2011. 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.

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

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

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

NSNA Membership Information

This health insurance Plan is available to NSNA members and their eligible Dependents only. Sustaining members enrolled in graduate degree programs are eligible to be enrolled in the Plan. For information on how you can join the NSNA, please visit www.nsna.org or all 1-718-210-0705 and NSNA staff will assist you.

Extension of Benefits After Termination

The coverage provided under this 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.

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

Pre-Admission Notification

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

1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY 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.

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

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

Schedule of Basic Medical Expense Benefits

Plan I (Low Option): Maximum Benefit $50,000 (For Each Injury or Sickness)
Plan II (High Option): Maximum Benefit $100,000 (For Each Injury or Sickness)
Deductible -0-

Plan I Only: Except as specified below, the Company will pay 80% of usual and customary charges incurred by an Insured due to a covered Injury or Sickness up to a Maximum Benefit of $50,000 for each Injury or Sickness.

Plan II Only: Except as specified below, the Company will pay 80% (unless otherwise specified) up to $20,000 of Covered Medical Expenses. After the company has paid $20,000 payment will be made for 100% of additional Covered Medical Expenses incurred not to exceed the $100,000 Maximum Benefit for each Injury or Sickness.

Please be aware that if you choose to change policies to upgrade coverage in any subsequent policy year, the benefit levels above your previous plans limits will be subject to a new Pre-existing Condition exclusion and waiting period. You will not be subject to a new pre-existing exclusion on the lower benefit levels.

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

U&C = Usual & Customary Charges

INPATIENT	Plan I (#240-11)	Plan II (#240-12)
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 U&C / $100 copay per admission / $900 maximum per day	100% of U&C / $100 copay per admission / $900 aggregate maximum per day
Intensive Care	80% of U&C	U&C
Routine Newborn Care	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care
Physiotherapy	Paid under Hospital Expense	Paid under Hospital Expense
Surgeon's Fees, in accordance with data provided by Ingenix. 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 U&C	U&C
Assistant Surgeon	30% of Surgery Allowance	30% of Surgery Allowance

INPATIENT	Plan I (#240-11)	Plan II (#240-12)
Anesthetist, professional services administered in connection with inpatient surgery.	30% of Surgery Allowance	30% of Surgery Allowance
Registered Nurse's Services, private duty nursing care.	80% of U&C	U&C
Physician's Visits, benefits do not apply when related to surgery.	80% of U&C	U&C
Pre-Admission Testing, payable within 7 working days prior to admission.	Paid under Hospital Expense	Paid under Hospital Expense
Mental Disorders	See Benefits for Treatment of Mental Disorders	See Benefits for Treatment of Mental Disorders
OUTPATIENT		
Surgeon's Fees, in accordance with data provided by Ingenix. 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 U&C	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 U&C / $800 maximum	U&C / $800 maximum
Assistant Surgeon	30% of Surgery Allowance	30% of Surgery Allowance
Anesthetist, professional services administered in connection with outpatient surgery.	30% of Surgery Allowance	30% of Surgery Allowance
Physiotherapy, benefits are limited to one visit per day. See exclusion #21 for additional limitations.	80% of U&C	U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of U&C / $20 copay per visit	100% of U&C / $20 copay per visit
Medical Emergency Expense, treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	100% of U&C / $50 copay per visit	100% of U&C / $50 copay per visit
Outpatient Miscellaneous Benefit, includes benefits designated as Paid under Outpatient Miscellaneous.	80% of U&C / $500 maximum per Injury or Sickness	U&C / $500 maximum per Injury or Sickness

OUTPATIENT	Plan I (#240-11)	Plan II (#240-12)
Diagnostic X-ray & Laboratory Services	Paid under Outpatient Miscellaneous	Paid under Outpatient Miscellaneous
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 Miscellaneous	Paid under Outpatient Miscellaneous
Injections, when administered in the Physician's office and charged on the Physician's statement.	No Benefits	No Benefits
Radiation Therapy & Chemotherapy	80% of U&C	U&C
Prescriptions, and medicines lawfully obtainable only upon written prescription of a Physician based on a 31-day supply per prescription.	80% of U&C / $15 copay per prescription / $250 maximum Per Policy Year	U&C / $15 copay per prescription / $500 maximum Per Policy Year
Mental Disorders	See Benefits for Treatment of Mental Disorders	See Benefits for Treatment of Mental Disorders
OTHER		
Ambulance Services	80% of U&C / $150 per trip	U&C / $150 per trip
Durable Medical Equipment	No Benefits	No Benefits
Consultant Physician Fees, when requested and approved by the attending Physician.	80% of U&C	U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth or fractured jaw.	80% of U&C	U&C
Alcoholism/Drug Abuse (Substance Abuse)	See Benefits for Treatment of Mental Disorders	See Benefits for Treatment of Mental Disorders
Maternity	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care	See Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion	No Benefits	No Benefits
Injury due to Needle Stick	80% of U&C	U&C

Optional Major Medical Benefit Plan I - $80,000 Maximum Benefit (For Each Injury or Sickness)

This optional benefit is subject to payment of an additional premium as specified on the enrollment card. Optional benefits may only be purchased at the time of initial enrollment in the Plan and may not be added later.

The Major Medical Benefit begins payment after the Basic Maximum Benefit of $50,000 has been paid by the Company.

The Company will pay 80% for additional Covered Medical Expenses incurred up to the Major Medical Maximum of $80,000. The total benefit payable under Major Medical is $130,000 minus the Basic Benefits already paid.

No benefits will be paid under Major Medical for:

1. Room & Board / Hospital Miscellaneous Expenses which exceed $900 aggregate maximum per day;
2. Dental treatment;
3. Mental Disorders in excess of the minimum mandated benefits specified in the Benefits for Treatment of Mental Disorders;
4. Services designated as "No Benefits" in the Basic Medical Expense Benefits Schedule of Benefits; or
5. Pre-existing Conditions, except for individuals who have been continuously insured under the Optional Major Medical coverage for at least 6 consecutive months; or under a previous qualifying health plan, provided such coverage was in force within 30 days prior to the Insured's Effective Date under this policy.

Optional Major Medical Benefit Plan II - $150,000 Maximum Benefit (For Each Injury or Sickness)

This optional benefit is subject to payment of an additional premium as specified on the enrollment card. Optional benefits may only be purchased at the time of initial enrollment in the Plan and may not be added later.

The Major Medical Benefit begins payment after the Basic Maximum Benefit of $100,000 has been paid by the Company.

The Company will pay 80% for additional Covered Medical Expenses incurred up to the Major Medical Maximum of $150,000. The total benefit payable under Major Medical is $250,000 minus the Basic Benefits already paid.

No benefits will be paid under Major Medical for:

1. Room & Board / Hospital Miscellaneous Expenses which exceed $900 aggregate maximum per day;
2. Dental treatment;
3. Mental Disorders in excess of the minimum mandated benefits specified in the Benefits for Treatment of Mental Disorders;
4. Services designated as "No Benefits" in the Basic Medical Expense Benefits Schedule of Benefits; or
5. Pre-existing Conditions, except for individuals who have been continuously insured under the Optional Major Medical coverage for at least 6 consecutive months; or under a previous qualifying health plan, provided such coverage was in force within 30 days prior to the Insured's Effective Date under this policy.

Coordination of Benefits Provision

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

Mandated Benefits

Benefits for Infertility Treatment

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Infertility for persons residing within the Commonwealth of Massachusetts to the same extent that benefits are provided for other pregnancy-related procedures. Benefits will include, but not be limited to, the following Non-experimental Infertility Procedures:

1) Artificial Insemination (AI);
2) In Vitro Fertilization and Embryo Placement (IVF-EP);
3) Gamete Intra-Fallopian Transfer (GIFT);
4) Sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such costs are not covered by the donor's insurer, if any;
5) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility; and
6) Zygote Intrafallopian Transfer (ZIFT).

Benefits are not provided for the following Experimental Infertility Procedures:

1) Any Experimental Infertility Procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner;
2) Surrogacy;
3) Reversal of Voluntary Sterilization; and
4) Cryopreservation of eggs.

"Infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year.

"Non-experimental Infertility Procedures" means a procedure which is: 1) recognized as such by the American Fertility Society (AFS) or the American College of Obstetrics and Gynecology (ACOG) or another infertility expert recognized as such by the Commission; and 2) incorporated as such in this provision by the Commissioner after a public hearing pursuant to M.G.L. c. 30A.

"Experimental Infertility Procedures" means a procedure not yet recognized as non-experimental.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or any other provisions of the policy, except that any Pre-Existing Condition exclusion or waiting period shall not apply to benefits for Infertility treatment.

Benefits for Cardiac Rehabilitation

Benefits will be paid the same as any other Sickness for Cardiac Rehabilitation. Cardiac Rehabilitation shall mean multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, which shall be provided in either a Hospital or other setting and which shall meet standards promulgated by the commissioner of public health. Benefits shall include, but not be limited to, outpatient treatment which is to be initiated within twenty-six (26) weeks after diagnosis of such disease.

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) an annual cytologic screening for women eighteen (18) years of age or older; and 2) a baseline mammogram for women between the ages thirty-five (35) and forty (40) and for an annual mammogram for women forty (40) years of age and older.

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

Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care

Benefits will be paid the same as any other Sickness for the expense of prenatal care, childbirth and post partum care. Benefits will be provided for a minimum of forty-eight hours of in-patient care following a vaginal delivery and a minimum of ninety-six hours of in-patient care following a caesarean section for a mother and her newly born child including routine well-baby care. Any decision to shorten such minimum stay shall be made by the attending Physician in consultation with the mother. Any such decision shall be made in accordance with rules and regulations promulgated by the Department of Public Health. Said regulations shall be relative to early discharge, defined as less than forty-eight hours for a vaginal delivery and ninety-six hours for a caesarean delivery. Post-delivery care shall include, but not be limited to, home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; provided, however, that the first home visit shall be conducted by a Physician. Additional Medically Necessary home visits shall be provided upon recommendation by a Physician.

Benefits will be paid the same as any other Sickness for Medically Necessary special medical formulas which are approved by the commissioner of the Department of Public Health, when prescribed by a Physician to protect the unborn fetuses of pregnant women with phenylketonuria.

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

Benefits for Enteral Formula

Benefits will be paid the same as any other Sickness for nonprescription enteral formulas for home use when a Physician has issued a written order for such formula and when Medically Necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. Benefits for inherited diseases of amino acids and organic acids shall include food products modified to be low protein limited to $5,000 annually for any Insured Person. Benefits are provided for formulas that are taken orally as well as those that are administered by tube.

Benefits shall be subject to a copayment for a 30-day supply of enteral formula that is equal to the copayment required for outpatient Physician Visits.

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

Benefits for Bone Marrow Transplants for Treatment of Breast Cancer

Benefits will be paid the same as any other Sickness for a bone marrow transplant or transplants for Insureds who have been diagnosed with breast cancer that has progressed to metastatic disease. Insureds must meet the criteria established by the Department of Public Health and which are consistent with medical research protocols reviewed and approved by the National Cancer Institute.

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

Benefits for Human Leukocyte Antigen or Histocompatibility Locus Antigen Testing

Benefits will be paid the same as any other Sickness for human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability for potential donors for Insured Persons. Benefits shall include the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.

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

Benefits for Initial Prosthetic Device and Reconstructive Surgery

Benefits will be paid the same as any other Sickness for a Mastectomy and the initial prosthetic device or reconstructive surgery incident to the Mastectomy. Benefits shall be provided for reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy. When a Mastectomy is performed and there is no evidence of malignancy, benefits will be limited to the cost of the prosthesis or reconstructive surgery to within 2 years after the date of the Mastectomy.

"Mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

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

Benefits for Scalp Hair Prostheses

Benefits will be paid for expenses for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia when a written statement by a Physician is furnished stating that the scalp hair prosthesis is Medically Necessary. Benefits are limited to $350 per Policy Year.

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

Benefits for Hospice Care

When an Insured Person is diagnosed with a covered Injury or Sickness, and therapeutic intervention directed toward the cure of the Injury or Sickness is no longer appropriate, and the Insured's medical prognosis is one in which there is a life expectancy of six months or less as a direct result of such Injury or Sickness, benefits will be payable for the Usual and Customary Charges for services and supplies for hospice care prescribed by a Physician and provided by a licensed hospice agency, organization or unit. This benefit does not cover non-terminally ill patients who may be confined in: a convalescent home, rest or nursing facility; a skilled nursing facility; a rehabilitation unit or a facility that provides treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts, or alcoholics. For this benefit to be payable, a written statement from the attending Physician that the Insured is terminally ill within the terms of this benefit and a written statement from the hospice certifying the days on which services were provided must be furnished to the Company.

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

Benefits for Home Health Care Services

Benefits will be paid the same as any other Sickness for Home Health Care Services. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aid and the use of durable medical equipment and supplies shall be provided to the extent such services are determined to be a Medically Necessary component of said nursing and physical therapy. Benefits for Home Health Care Services are payable only when such services are Medically Necessary and provided in conjunction with a Physician approved Home Health Care Services plan. Durable medical equipment and supplies provided as part of an approved Home Health Care Services plan will not be subject to any policy limitations regarding durable medical equipment and supplies.

"Home health care services" means health care services for an Insured Person by a public or private home health agency which meets the standards of service of the purchaser of service, provided in a patient's residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Said services shall include, but not be limited to, nursing and physical therapy.

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

Benefits for Treatment of Diabetes

Benefits will paid the same as any other Sickness for Insured Persons for Medically Necessary services and supplies for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes when prescribed by a Physician.

Benefits will be paid for the following, subject to any applicable Deductibles, co-payments and coinsurance shown on the Schedule of Benefits:

1. Prescription Drugs: blood glucose monitoring strips for home use; urine glucose strips; ketone strips; lancets; insulin; insulin syringes; insulin pumps and insulin pump supplies; insulin pens and prescribed oral diabetes medications that influence blood sugar levels;
2. Durable medical equipment: blood glucose monitors; voice-synthesizers for blood glucose monitors for use by the legally blind; visual magnifying aids for use by the legally blind;
3. Laboratory/radiological services: including glycosylated hemoglobin, or HbAlc tests; urinary protein/microalbumin and lipid profiles;
4. Prosthetics: therapeutic/molded shoes and shoe inserts prescribed by a Physician and approved by the Federal Drug Administration for the purposes for which they were prescribed for Insureds who have severe diabetic foot disease; and
5. Outpatient services: diabetes outpatient self-management training and education, including medical nutrition therapy, when provided by a Physician certified in diabetes health care

As used in this section, a “Physician certified in diabetes health care" means a licensed health care professional with expertise in diabetes, a registered dietician or a health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

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

Benefits for Treatment of Speech, Hearing and Language Disorders

Benefits will be paid the same as any other Sickness for Insured Persons for Medically Necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists if such services are rendered within the lawful scope of practice for such speech-language pathologists or audiologists. Benefits will be paid for services provided in a Hospital, clinic or private office. Benefits will not be provided for the diagnosis or treatment of speech, hearing and language disorders for services provided in a school-based setting.

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

Benefits for Off-Label Drug Use

If benefits are payable for Prescription Drugs under this policy (see Schedule of Benefits), then benefits will be paid the same as any other Prescription Drug for any drug prescribed to treat an Insured Person for cancer or HIV/AIDS if the drug is recognized treatment for that indication in one of the standard reference compendia or in the medical literature.

"Standard reference compendia" means (a) the United States Pharmacopeia Drug Information; (b) the American Medical Association Drug Evaluations; or (c) the American Hospital Formulary Service Drug Information.

"Medical literature" means scientific studies published in any peer-reviewed national professional journal.

For such Prescription Drugs that are payable due to establishment by the commissioner as payable after a review of the panel of medical experts as outlined in Massachusetts Insurance Code, 175:47L, benefits will be paid for such drugs that are not included in any of the standard reference compendia or in the medical literature for the treatment of cancer.

Benefits shall include Medically Necessary services associated with the administration of such drugs.

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

Benefits for Prosthetic Devices and Repairs

Benefits will be paid for Medically Necessary Prosthetic Devices and repairs under the same terms and conditions that apply to other durable medical equipment except that no annual or lifetime dollar maximum applicable to other durable medical equipment shall be imposed unless the annual or lifetime dollar maximum applies in the aggregate to all items and services covered under the policy.

"Prosthetic device" means an artificial limb device to replace, in whole or in part, an arm or leg.

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

Benefits for Hypodermic Syringes or Needles

Benefits will be paid for the Covered Medical Expenses incurred for medically necessary hypodermic syringes and needles.

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

Benefits for Treatment of Mental Disorders

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, referred to in this benefit as the "DSM":

1) schizophrenia,
2) schizoaffective disorder,
3) major depressive disorder,
4) bipolar disorder,
5) paranoia and other psychotic disorders,
6) obsessive-compulsive disorder,
7) panic disorder,
8) delirium and dementia,
9) affective disorders,
10) eating disorders,
11) post traumatic stress disorder,
12) substance abuse disorders, and
13) autism.

Benefits will be paid the same as any other sickness for the diagnosis and medically necessary active treatment of any Mental Disorder as described in the most recent edition of the DSM that is approved by the Commissioner of Mental Health.

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape, as defined by sections 22 and 24 of chapter 265, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant to subparagraph (C) of paragraph (2) of subsection (b) of section 3 of chapter 258C.

Benefits will be paid the same as any other Sickness for an Insured Person under the age of 19 for the diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, which substantially interfere with or substantially limit the functioning and social interactions of such a child provided, that said interference or limitation is documented by and the referral for said diagnosis and treatment is made by a Physician, or is evidenced by conduct, including, but not limited to:

1) an inability to attend school as a result of such disorder,
2) the need to hospitalize such Insured Person as a result of such disorder, or
3) a pattern of conduct or behavior caused by such disorder which poses a serious danger to self or others.

Such benefits to an Insured Person who is engaged in an ongoing course of treatment shall continue beyond the Insured Person's nineteenth birthday until said course of treatment, as specified in such Insured Person's treatment plan, is completed and while the policy under which such benefits first became available remains in effect, or subject to a subsequent policy which is in effect.

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of all other mental disorders not otherwise provided for in this benefit section and which are described in the most recent edition of DSM during each 12 month period but shall never exceed:

1) 60 days of inpatient treatment; and
2) 24 outpatient visits.

Benefits shall include inpatient, intermediate, and outpatient services that are Medically Necessary and provided in the least restrictive clinically appropriate setting.

Inpatient services may be provided in a general Hospital licensed to provide such services, in a facility under the direction and supervision of the Department of Mental Health, in a private mental Hospital licensed by the Department of Mental Health, or in a substance abuse facility licensed by the Department of Public Health.

Intermediate services shall include, but not be limited to, Level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Public Health or the Department of Mental Health.

Outpatient services may be provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the Department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

Benefits will be paid the same as any other Sickness for psychopharmacological services and neuropsychological assessment services.

When necessary for administration of claims under this benefit section, consent to the disclosure of information regarding services for mental disorders will be required on the same basis as disclosure of information for other Sickness or Injury.

Benefits will not be payable for mental health benefits or services: which are provided to a person who is incarcerated, confined or committed to a jail, house of correction or prison, or custodial facility in the department of youth services within the commonwealth or one of its political subdivisions; which constitute educational services required to be provided by a school committee pursuant to section 5 of chapter 71B; or which constitute services provided by the Department of Mental Health.

"Licensed mental health professional" means a Physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist.

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

Benefits for Hormone Replacement Therapy and Outpatient Contraceptive Services

Benefits will be paid the same as any other Sickness for outpatient hormone replacement therapy services for peri and post menopausal women and outpatient contraceptive services. Outpatient contraceptive services include consultations, examinations, procedures and medical services for all United States Food and Drug Administration (FDA) approved contraceptive methods to prevent pregnancy.

If the policy provides benefits for Prescription Drugs, benefits will be paid the same as any other Sickness for FDA approved hormone replacement therapy and outpatient prescription contraceptive drugs or devices.

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

Benefits for Qualified Clinical Trials for Treatment of Cancer

Benefits will be paid the same as any other Sickness for Patient Care Service furnished pursuant to a Qualified Clinical Trial.

Patient Care Service means a health care item or service that is furnished to an individual enrolled in a Qualified Clinical Trial which is consistent with the Usual and Customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial.

Qualified clinical trial means a clinical trial that meets the following conditions:

1. the clinical trial is to treat cancer;
2. the clinical trial has been peer reviewed and approved by one of the following;
    a. United States National Institutes of Health;
    b. A cooperative group or center of the National Institutes of Health;
    c. A qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
    d. The United States Food and Drug Administration pursuant to an investigational new drug exemption;
    e. The United States Departments of Defense or Veterans Affairs; or
    f. With respect to Phase II, III and IV clinical trials only, a qualified institutional review board.
3. the facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that experience;
4. with respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility and the clinicians conducting the trial shall have staff privileges at said academic medical center;
5. the patient meets the patient selection criteria defined in the study protocol for participation in the clinical trial;
6. the patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards;
7. the available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial;
8. the clinical trial does not unjustifiably duplicate existing studies; and
9. the clinical trial must have a therapeutic intent and must, to some extent, assume the effect of the intervention on the patient.

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

Benefits for Christian Science Services

Benefits will be paid for services delivered in accordance with the healing practices of Christian Science. The cost sharing and any aggregate maximum per day applicable to Room and Board and Hospital Miscellaneous Expenses or, if combined, Hospital Expense, stated in the Schedule of Benefits will apply to services in a Christian Science sanatorium.

All Deductibles, copayments, coinsurance, limitations or any other provisions of the policy shall also apply to the services of Christian Science sanatoria. Religious aspects of care are not covered under this benefit.

Benefits for Newborn or Adopted Children

Benefits will be paid for Newborn Infants, including Newborn Infants of a Dependent, from the moment of birth the same as any other Insured Dependent. Benefits shall also be provided for adopted or adoptive children of the Insured Person immediately from the date of the filing of a petition to adopt under chapter two hundred and ten and thereafter if the child has been residing in the home of the Insured Person as a foster child for whom the Insured Person has been receiving foster care payments, or, in all other cases, immediately from the date of placement by a licensed placement agency of the child for purposes of adoption in the home of the Insured Person. Benefits for Newborn infants and adoptive children shall include treatment of Injury and Sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth.

Benefits shall include those special medical formulas which are approved by the commissioner of the Department of Public Health, prescribed by a Physician, and are Medically Necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children.

Benefits shall include screening for lead poisoning on the basis required by the Department of Public Health.

Benefit shall include a newborn hearing screening test to be performed before the Newborn Infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the Department of Public Health.

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

Benefits for Dependent Children Preventive Care

Benefits will be paid for the Usual and Customary Charges for those preventive and primary services delivered or supervised by a Physician that are rendered to a Dependent child of an Insured from the date of birth through the attainment of six years of age. Benefits include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Benefits shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician. Benefits shall include those special medical formulas which are approved by the commissioner of the Department of Public Health, prescribed by a Physician, and are Medically Necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children.

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

Benefits for Dependent Children Early Intervention Services

Benefits will be paid the same as any other Sickness for early intervention services for Dependent children from birth to their third birthday. Certified early intervention specialists in accordance with an early intervention program approved by the Department of Public Health and in accordance with applicable certification requirements shall provide early intervention services.

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

Definitions

ADOPTED OR ADOPTIVE CHILD means: 1) a child from the date of the filing of petition to adopt, who has been residing in the home of the Insured as a foster child and the Insured has been receiving foster care payments; provided the person adopting the child is insured under the policy on the date the petition is filed; or 2) a child from the date of placement by a licensed placement agency for purposes of adoption in the home of the Insured provided the person adopting the child is insured under this policy on the date the child is placed with the Insured.

Such child will be covered under the policy for the first 31 days after: 1) date of the filing of a petition to adopt a foster child; or 2) date of placement of a child for purposes of adoption.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, a) apply to the Company and b) pay the required additional premium (if any) for the continued coverage within 31 days after 1) filing of a petition to adopt; or 2) date of placement for purposes of adoption.

If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the date of filing of: 1) filing of a petition to adopt; or 2) date of placement of a child for purposes of adoption.

COMPLICATION OF PREGNANCY means a condition 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy. The term "complication of pregnancy" includes non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; hyperemesis gravidarum; and pre-eclampsia.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any. Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

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

DEPENDENT means the spouse (husband or wife) of the Named Insured and their dependent, unmarried children and any Newborn Infant of a dependent of the Named Insured. Children shall cease to be dependent on the first to occur of:

1) The end of the month in which they marry; or,

2) The end of the month in which they attain the age of nineteen (19) years; or 23 years, if a full-time dependent student at an accredited institution of higher learning.

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

1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and,

2) Chiefly dependent upon the Insured Person for support and maintenance.

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

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2).

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

EXPERIMENTAL OR INVESTIGATIVE TREATMENT means a service, supply, procedure, device or medication that meets any of the following: 1) a drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished or to be furnished; or 2) a treatment, or the "informed consent" form used with a treatment, that was reviewed and approved by the treating facility's institutional review board or other body servicing a similar function, or federal law requires such review or approval; or 3) reliable evidence shows that the treatment is the subject of ongoing Phase I or Phase II clinical trials; is the research, experimental, study or investigative arm of ongoing Phase III clinical trials; or is otherwise under study to determine its safety, efficacy, toxicity, maximum tolerated dose, or its efficacy as compared with a standard means of treatment or diagnosis; or 4) reliable evidence shows that prevailing opinion amount experts regarding the treatment is that more studies or clinical trials are necessary to determine its safety, efficacy, toxicity, maximum tolerated does, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence, as used in this definition, means only published reports and articles in the authoritative peer-reviewed medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment; or the written informed consent form used by the treating facility or by another facility studying substantially the same treatment.

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

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

INJURY means bodily injury 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.

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

INTENSIVE CARE means: 1) a specifically designed facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the Intensive Care Unit. Intensive Care does not mean any of these step-down units: 1) Progressive care; 2) Sub-acute intensive care; 3) Intermediate care units; 4) Private monitored rooms, 5) Observation units; or 6) Other facilities which do not meet the standards for Intensive Care.

MEDICAL EMERGENCY means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in 1) placing the health of the Insured Person in serious jeopardy; 2) serious impairment to body function, or serious dysfunction of any body organ or part; or 3) with respect to a pregnant woman, the health of the woman or her unborn child.

MEDICAL NECESSITY or MEDICALLY NECESSARY means those services or supplies provided or prescribed by a Hospital or Physician which are: 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; and, 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: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient. This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

MENTAL DISORDER means a Sickness that is a mental, emotional or behavioral disorder. If not excluded or defined elsewhere in the policy, all diagnoses classified as a "Mental Disorder" according to the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association are considered one Sickness.

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

NEWBORN INFANT means any child born of an Insured or of the Insured's Dependent while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the Insured Person's immediate family. This includes but is not limited to certified registered nurse anesthetists, nurse practitioners, certified nurse midwives, podiatrists, chiropractors, optometrists or any other legally licensed practitioner of the healing arts who is practicing within the scope of his/her license. Physician's eligible for reimbursement under the terms of this policy shall include pediatric specialty care Physicians, including mental health care, by Physicians with recognized expertise in specialty pediatrics to eligible Insureds requiring such services. The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

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

PRE-EXISTING CONDITIONS means any condition (1) which manifested itself during the 6 months immediately preceding the Insured's Effective Date of Coverage under this policy and would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received, or (2) a pregnancy existing on the Insured's Effective Date of Coverage under the Policy.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

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

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

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not curious, abscessed, or defective.

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

Exclusions and Limitations

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

1. Acne; acupuncture; allergy, including allergy testing;
2. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3. Biofeedback;
4. Durable Medical Equipment;
5. Injections;
6. Circumcision;
7. Congenital conditions, except as specifically provided for Newborn or Adopted Infants;
8. 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; removal of warts, non-malignant moles and lesions;
9. Dental treatment, except as specifically provided in the Schedule of Benefits;
10. Elective Surgery or Elective Treatment;
11. Elective abortion;
12. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
13. Foot care including: care of corns, bunions (except capsular or bone surgery), calluses,
14. Hearing examinations or hearing aids; or other treatment for hearing defects and problems, except as specifically provided in the policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; alopecia;
16. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
17. Injury caused by, contributed to, or resulting from the use of intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician;
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
19. Injury sustained while (a) participating in any interscholastic, club, 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;
20. Organ transplants, including organ donation;
21. 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;
22. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
23. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 6 consecutive months; or under a previous qualifying health plan, provided such coverage was in force within 30 days prior to the Insured's Effective Date under this policy;

24. Prescription Drugs, services or supplies as follows:
    a. Therapeutic devices or appliances, including: support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy;
    b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
    c. Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the policy;
    d. Products used for cosmetic purposes;
    e. Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f. Anorectics - drugs used for the purpose of weight control;
    g. Sexual enhancement drugs, such as Viagra;
    h. Growth hormones; or
    i. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
25. Family planning; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery;
26. 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;
27. Routine Newborn Infant Care, well-baby nursery and related Physician charges, except as specifically provided in the Benefits for Maternity, Childbirth, Well-Baby and Post Partum Care;
28. Nasal and sinus surgery;
29. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
30. Sleep disorders;
31. Supplies, except as specifically provided in the policy;
32. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
33. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
34. 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); and
35. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat.

Claim Procedure

Students should:

1. 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 Association (NSNA) under which the student is insured. A company claim form is not required for filing a claim.
2. 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.
3. Benefits will be paid within forty-five (45) days of receipt of a claim. If payment is not made, the Company will notify the Insured in writing specifying the reasons for the nonpayment or what additional documentation is necessary for payment of the claim. If the Company fails to comply with the terms of this provision, in addition to any benefits payable, interest on such benefits will accrue beginning forty-five (45) days after receipt of the claim at a rate of one and one-half (1 1/2) percent per month, not to exceed eighteen (18) percent per year. The interest payments shall not apply to a claim which the Company is investigating because of suspected fraud.

Submit all Claims to:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025

For information on a specific claim or to check the status of a claim, please contact:

UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, TX 75380-9025
1-800-505-5450

National Student Nurses' Association, Inc.
45 Main St., Suite 606
Brooklyn, NY 11201
718-210-0705
E-mail: nsna@nsna.org
Website: www.nsna.org

This plan is underwritten by:
UnitedHealthcare Insurance Company

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

This brochure is based on Policy # 2010-240-11 (Plan I - Low Option)
and 2010-240-12 (Plan II - High Option) v1