2011-2012

Student Injury and Sickness Insurance Plan

LIMITED BENEFIT PLAN. PLEASE READ CAREFULLY

DESIGNED ESPECIALLY FOR THE STUDENTS OF

ACSA
AMERICAN COLLEGE STUDENT ASSOCIATION

For New York Residents Only

UnitedHealthcare®
A UnitedHealth Group Company

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.

06-BR-NY (Rev 09)

31-2101-30/31

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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

(Plan I - 2011-2101-30 - High Option) and (Plan II - 2011-2101-31 - Low Option) All registered domestic undergraduate students taking 6 hours (3 hours during summer sessions); all graduate students taking 3 or more hours and/or registered for thesis or dissertation (maximum for one year if not taking credit hours); all registered students taking classes via the internet are eligible to enroll in this insurance Plan. The student would have to be registered for and taking classes on campus in order for internet classes to qualify toward meeting the eligibility requirements. All students enrolled in a college, university, community college or technical school may purchase this plan as long as the eligibility requirements are met.

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 attend classes. The Company maintains its right to investigate student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers that 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 or Domestic Partner and unmarried children under 19 years of age, 23 years, if a full-time dependent student at an accredited institution of higher learning who are not self-supporting. Full-time dependent students who take a medical leave of absence from school may continue to be dependent for a period of 12 months from the last day of attendance, provided, however that the coverage will not extend beyond the limiting age for full-time students. Dependent Eligibility expires concurrently with that of the Insured student. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Choice of Plan

Each eligible student has a choice of one of the benefit plans. Plan I (2011-2101-30) has higher benefits than Plan II (2011-2101-31) and it has a higher premium. Make your selection carefully, you cannot upgrade coverage after the initial purchase of the plan for the policy year. Please be aware that if you choose to upgrade coverage in any subsequent policy year, a new Pre-existing Condition exclusion and waiting period will apply.

Effective and Termination Dates

The Master Policy on file at the Association headquarters becomes effective 12:01 a.m., August 1, 2011. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates 11:59 p.m., July 31, 2012. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student. Refunds of premiums are allowed only upon entry into the armed forces.

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

Extension of Benefits after Termination

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

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

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

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.

High Option Plan #2011-2101-30
Schedule of Medical Expense Benefits
Up To $100,000 Maximum Benefit
Paid as Specified Below (For Each Injury or Sickness)
Preferred Provider Deductible $250 (Per Insured Person) (Per Policy Year)
Out-of-Network Deductible $500 (Per Insured Person) (Per Policy Year)

The Policy provides benefits for the Usual & Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $100,000 for each Injury or Sickness.

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

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.

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

PA = Preferred Allowance U&C = Usual & Customary Charges
max=Maximum

INPATIENT	Preferred Providers	Out-of-Network Providers
Hospital Expense, daily semi-private room rate; and 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. *Copay/Deductible is in addition to plan Deductible.*	90% of PA / $200 copay per admission	60% of U&C / $400 Deductible per admission
Intensive Care	90% of PA	60% of U&C
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth.	See Benefits for Maternity Expenses	
Physiotherapy	90% of PA	60% of U&C
Surgeon's Fees, *$5,000 max,* in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	60% of U&C
Assistant Surgeon	No Benefits	
Anesthetist, professional services in connection with inpatient surgery.	90% of PA	60% of U&C

INPATIENT	Preferred Providers	Out-of-Network Providers
Registered Nurse's Service, private duty nursing care.	90% of PA	60% of U&C
Physician's Visits, benefits are limited to one visit per day and do not apply when related to surgery.	90% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	90% of PA	60% of U&C
Psychotherapy, benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances	
OUTPATIENT		
Surgeon's Fees, *$5,000 max,* in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	90% of PA	60% of U&C
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests, and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Day Surgery Miscellaneous Charges are based on the Outpatient Surgical Facility Charge Index. *Copay/Deductible is in addition to plan Deductible.*	90% of PA / $200 copay per Injury or Sickness	60% of U&C / $400 Deductible per Injury or Sickness
Assistant Surgeon	No Benefits	
Anesthetist, professional services administered in connection with outpatient surgery.	90% of PA	60% of U&C
Physician's Visits, including chiropractic care, benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy. *Copay/Deductible is in lieu of plan Deductible.*	90% of PA / $20 copay per visit	60% of U&C / $40 Deductible per visit
Medical Emergency Expenses, *$600 max,* use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. *Copay/Deductible is in addition to plan Deductible.*	90% of PA / $50 copay per visit	90% of U&C / $50 Deductible per visit
Physiotherapy, all chiropractic care is payable under Physician's Visits. Benefits are limited to one visit per day. See exclusion number 13 for additional limitations. *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Copay/Deductible is in addition to the plan Deductible.*	90% of PA /$20 copay per visit	60% of U&C / $20 Deductible per visit
Injections	No Benefits	
Diagnostic X-ray & Laboratory Services, *$950 max*	90% of PA / $20 copay per X-ray or test	60% of U&C/ $40 Deductible per X-ray or test

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Radiation Therapy & Chemotherapy	90% of PA / $50 copay per visit	60% of U&C / $100 Deductible per visit
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	90% of PA	60% of U&C
Psychotherapy, benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances	
Prescription Drugs	UnitedHealthcare Network Pharmacy $15 copay per prescription for Tier 1 / $30 copay per prescription for Tier 2 / $50 copay per prescription for Tier 3 / up to a 31-day supply per prescription / $1,000 maximum (Per Policy Year)	No Benefits
OTHER		
Ambulance Services, *$1,000 maximum per trip*	90% of PA / $50 copay per trip	60% of U&C / $50 Deductible per trip
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	90% of PA / $50 copay per Injury or Sickness	60% of U&C / $50 Deductible per Injury or Sickness
Consultant Physician Fees, when requested and approved by the attending Physician.	90% of PA / $50 copay per visit	60% of U&C / $50 Deductible per visit
Dental Treatment, made necessary by Injury to Sound, Natural Teeth.	90% of U&C	90% of U&C
Chemical Dependence: (Alcoholism/Drug Abuse)	See Benefits for Chemical Dependence (Alcoholism/Drug Abuse)	
Maternity	See Benefits for Maternity Expenses	
Elective Abortion	No Benefits	
Complications of Pregnancy	Paid as any other Sickness	
Intercollegiate Sports, *$5,000 max for each Injury*	Paid as any other Injury	
CAT Scan/MRI, *$2,000 maximum Per Policy Year*	PA / $50 copay per procedure	U&C / $50 Deductible per procedure

Low Option Plan #2011-2101-31

Schedule of Medical Expense Benefits

Up To $50,000 Maximum Benefit

Paid as Specified Below (For Each Injury or Sickness)

Preferred Provider Deductible $350 (Per Insured Person) (Per Policy Year)

Out-of-Network Deductible $700 (Per Insured Person) (Per Policy Year)

The Policy provides benefits for the Usual & Customary Charges incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $50,000 for each Injury or Sickness.

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

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.

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

PA = Preferred Allowance U&C = Usual & Customary Charges Max=Maximum

INPATIENT	Preferred Providers	Out-of-Network Providers
Hospital Expense, daily semi-private room rate; and 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. *Copay/Deductible is in addition to plan deductible.*	80% of PA / $200 copay per admission	60% of U&C / $1,200 max per day / $200 Deductible per admission
Intensive Care	Paid under Hospital Expense	
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth.	See Benefits for Maternity Expenses	
Physiotherapy	80% of PA	60% of U&C
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA / $5,000 max	60% of U&C / $2,500 max
Assistant Surgeon	No Benefits	
Anesthetist, professional services in connection with inpatient surgery.	25% of Surgery Allowance	25% of Surgery Allowance

INPATIENT	Preferred Providers	Out-of-Network Providers
Registered Nurse's Service, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, benefits are limited to one visit per day and do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of U&C
Psychotherapy, benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances	
OUTPATIENT		
Surgeon's Fees, in accordance with data provided by FAIR Health, Inc. If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA / $5,000 max	60% of U&C / $2,500 max
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. Day Surgery Miscellaneous Charges are based on the Outpatient Surgical Facility Charge Index. *Copay/Deductible is in addition to plan Deductible.*	80% of PA / $200 copay per Injury or Sickness	60% of U&C / $1,400 max / $200 Deductible per Injury or Sickness
Assistant Surgeon	No Benefits	
Anesthetist, professional services administered in connection with outpatient surgery.	25% of Surgery Allowance	25% of Surgery Allowance
Outpatient Miscellaneous Benefit, includes benefits designated as Paid under Outpatient Miscellaneous Benefit.	No Benefits	60% of U&C / $750 max
Physician's Visits including chiropractic care, benefits are limited to one visit per day. Benefits for Physician's Visits do not apply when related to surgery or Physiotherapy. *Copay/Deductible is in lieu of plan Deductible.*	80% of PA / $25 copay per visit	60% of U&C / $25 Deductible per visit
Medical Emergency Expenses, *$400 maximum.* Use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. Maximum applies if not admitted. *Copay/Deductible is in addition to plan Deductible.*	80% of PA / $50 copay per visit	80% of U&C / $50 Deductible per visit
Physiotherapy, all chiropractic care is payable under Physician's Visits. Benefits are limited to one visit per day. See exclusion number 13 for additional limitations. *Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. Copay/Deductible is in addition to plan Deductible.*	80% of PA / $25 copay per visit	60% of U&C / $25 Deductible per visit

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Injections	No Benefits	
Diagnostic X-ray & Laboratory Services	80% of PA / $800 max / $25 copay per X-ray or Test	Paid under Outpatient Misc. Benefit / $25 Deductible per X-ray or Test
Radiation Therapy & Chemotherapy	80% of PA / $50 copay per visit	Paid under Outpatient Misc. Benefit / $50 Deductible per visit
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	80% of PA	Paid under Outpatient Misc. Benefit
Prescription Drugs, **Preferred Provider:** *$500 maximum Per Policy Year*	UnitedHealthcare Network Pharmacy / $15 copay per prescription for T ier 1 / $30 copay per prescription for Tier 2 / $50 copay per prescription for Tier 3 / up to a 31-day supply per prescription	No Benefits
Psychotherapy, benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances	
OTHER		
Ambulance Services, *$400 max per trip*	80% of PA / $50 copay per trip	60% of U&C / $50 Deductible per trip
Durable Medical Equipment, *$400 max.* A written prescription must accompany the claim when submitted. Replacement equipment is not covered.	80% of PA / $50 copay per Injury or Sickness	60% of U&C / $50 Deductible per Injury or Sickness
Consultant Physician Fees, *$200 maximum.* When requested and approved by the attending Physician.	80% of PA / $50 copay per visit	60% of U&C / $50 Deductible per visit
Dental Treatment, *$500 max.* Made necessary by Injury to Sound, Natural Teeth.	80% of U&C	80% of U&C
Chemical Dependence: (Alcoholism/Drug Abuse)	See Benefits for Chemical Dependence (Alcoholism/Drug Abuse)	
Maternity	See Benefits for Maternity Expenses	
Elective Abortion	No Benefits	
Complications of Pregnancy	Paid as any other Sickness	
Intercollegiate Sports, *$5,000 max*	Paid as any other Injury	
CAT Scan/MRI, *$1,000 maximum Per Policy Year*	PA / $50 copay per procedure	U&C / $50 Deductible per procedure

Preferred Provider Information

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

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-5450 and/or by asking the provider when making an appointment for services.

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

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

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

UnitedHealthcare Network Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits and copayment/coinsurance that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable copayment. Your copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 1-877-417-7345 for the most up-to-date tier status.

High Option 2011-2101-30

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

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

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

Your maximum allowed benefit is $1,000 maximum Per Policy Year.

Low Option 2011-2101-31

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

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

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

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

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

Additional Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.

3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, 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 1-877-417-7345.

Maternity Testing

This policy does not cover routine, preventive or screening examinations or testing unless Medical Necessity is established based on medical records. The following maternity routine tests and screening exams will be considered if all other policy provisions have been met: **Initial screening at first visit** – Pregnancy test: Urine human chorionic gonatropin (HCG), Asymptomatic bacteriuria: Urine culture, Blood type and Rh antibody, Rubella, Pregnancy-associated plasma protein-A (PAPPA) (first trimester only), Free beta human chorionic gonadotrophin (hCG) (first trimester only), Hepatitis B: HBsAg, Pap smear, Gonorrhea: Gc culture, Chlamydia: chlamydia culture, Syphilis: RPR, HIV: HIV-ab; and Coombs test; **Each visit** – Urine analysis; **Once every trimester** – Hematocrit and Hemoglobin; **Once during first trimester** – Ultrasound; **Once during second trimester** – Ultrasound (anatomy scan); Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a; **Once during second trimester if age 35 or over** - Amniocentesis or Chorionic villus sampling (CVS); **Once during second or third trimester** – 50g Glucola (blood glucose 1 hour postprandial); and **Once during third trimester** - Group B Strep Culture. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-505-5450.

Interscholastic Sports

$5,000 Maximum Benefit (For Each Injury)
Coinsurance High Option: Preferred Providers 90%, Out of Network Providers 60%
Coinsurance Low Option: Preferred Providers 80%, Out of Network Providers 60%

Insured student athletes who are members of and are participating in intercollegiate Football, Baseball, Softball, Basketball, Volleyball, Soccer, Cheerleading, Rugby, Golf, Tennis, Rifle, Hockey, Swimming, Track and Field, Equestrian, Wrestling, Boxing, Lacrosse, Gymnastics, and Skating, Cross Country, Rowing, Fencing, Squash, Skiing, Crew, Rodeo, and Bowling. are covered for sports Injury as follows:

Benefits will be paid under the Schedule of Benefits for interscholastic sports Injury up to $5,000 for each Injury.

Accidental Death & 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. Payment under this benefit will not exceed the policy Maximum Benefit.

For Loss Of:

Life	$5,000
Two or More Members	$5,000
One Members	$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.

Coordination of Benefits

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

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 deductibles, 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 Contraceptive Drugs or Devices

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 Diabetes Expense

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 include 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 anti-diabetic agents used to reduce blood sugar levels;

(i) alcohol swabs;

(j) syringes;

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

(l) cartridges for the visually impaired;

(m) disposable insulin cartridges and pen cartridges;

(n) all insulin preparations;

(o) insulin pumps and equipment for the use of the pump including batteries;

(p) insulin infusion devices;

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

(r) glucagon for injection to increase blood glucose concentration.

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 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 subject to the following limits:

Outpatient Treatment:

Outpatient benefits are limited to one outpatient visit per day and include the following:

(a) up to a maximum of 60 outpatient visits per calendar year for the Insured Person in need of treatment;

(b) up to a maximum of 20 visits per calendar year for covered Family Members, (including visits for remediation through counseling and education), provided that the total number of such visits, when combined with those of the Insured Person in need of treatment, does not exceed 60 visits in any calendar year.

Inpatient Treatment:

Inpatient benefits in a Hospital or a detoxification facility will be paid the same as any other Sickness not to exceed 7 days of active treatment per policy year. For rehabilitation services, benefits will be paid the same as any other Sickness not to exceed 30 days of inpatient care per policy year.

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.

"**Family Member**" means those family members covered under the insurance policy covering the person receiving or in need of treatment for alcoholism or substance abuse.

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 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 for the treatment of breast cancer.

Breast reconstructive surgery after a 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 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 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 Prostate Screening

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer for an Insured at any age with a prior history of prostate cancer; at age 50 and over for Insureds who are asymptomatic; and at age 40 and over for Insureds with a family history of prostate cancer or other prostate cancer risk factors.

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

Benefits for 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 Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information; or
3. the United States Pharmacopeia Drug Information; or
4. recommended by review article or editorial comment in a major peer reviewed professional journal.

Benefits will not be paid for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

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 Bone Mineral Density Measurements or Tests

Benefits will be paid the same as any other Sickness for bone mineral density measurements or tests, and if coverage for Prescription Drugs, drugs and devices is otherwise provided in the policy, coverage 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 heath, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

Individuals qualifying for coverage 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;

(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 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 Insured's 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 Mental and Nervous Disorder Treatment

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of mental, nervous or emotional disorders. Benefits for inpatient Hospital care are limited to 30 days of Active Treatment per policy year. For the purpose of this benefit, two partial days of Hospital Confinement will be combined to equal one day of inpatient Hospital care. Outpatient care provided by a Physician or facility licensed by the commissioner of mental health or operated by the office of mental health is limited to 20 visits per policy year.

"Active Treatment" means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations or other provision 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 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.

Definitions

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; c) joint ownership or holding of investments; d) joint ownership of residence or ownership of real estate other than residence; e) listing of both partners as tenants on the lease of the shared residence; f) shared rental payments of residence; g) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence; h) a common household and shared household expenses; i) shared household budget for purposes of receiving government benefits; j) status of one as representative payee for the other's government benefits; k) joint ownership of major items of personal property; l) joint ownership of a motor vehicle; m) joint responsibility for child care; n) shared child-care expenses; o) execution of wills naming each other as executor and/or beneficiary; p) designation as beneficiary under the other's life insurance policy or the other's retirement benefits account; q) mutual grant of durable power of attorney; r) mutual grant of authority to make health care decisions; s) affidavit by creditor or other individual able to testify to partners' financial interdependence; or t) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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.

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

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

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. Assistant Surgeon Fees;
2. Chemical Dependence (Alcoholism/Drug Abuse), except as specifically provided in Benefits for Chemical Dependence (Alcoholism/Drug Abuse);
3. 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;
4. Dental treatment, except for accidental Injury to Sound, Natural Teeth or due to congenital disease or anomaly;
5. Elective Surgery or Elective Treatment;
6. Elective Abortion;
7. Eye examinations, prescriptions or fitting of eyeglasses or contact lenses. Vision correction, or other treatment for visual defects and problems; except when due to a disease process or a Medical Necessity;
8. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of feet;
9. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
10. The Insured's being intoxicated or under the influence of any narcotic unless administered on the advise of a Physician;
11. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
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 cares 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. 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;
14. Participation in a felony, riot or insurrection;
15. Pre-existing Conditions, except for individuals who have been continuously insured under the school's 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 continuous to a date not more than 63 days prior to the Insured's enrollment date under this policy;
16. Prescription Drugs, services or supplies as follows:
    a. Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as

specifically provided in the Benefits for Diabetes Expense;

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

c. Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra, except when a Medical Necessity;

d. Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

17. Preventive medicines, serums, vaccines or immunizations; except as specifically provided in the policy;
18. Routine Newborn Infant Care, well-baby nursery and related Physician charges, except as specifically provided in the Benefits for Maternity Expense;
19. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
20. Services provided normally without charge by the Student Health Center of the Policyholder; or services covered or provided by the student health fee;
21. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
22. Suicide or attempted suicide or intentionally self-inflicted Injury;
23. Supplies, except as specifically provided in the policy;
24. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
25. Treatment, service or supply which is not a Medical Necessity, subject to Article 49 of N.Y. Insurance Law; and
26. 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, health information, and counseling support 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

Scholastic Emergency Services: Global Emergency Medical Assistance

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

Domestic Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible for SES 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.

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

Key Services include:

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

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

To access services please call:
(877) 488-9833 Toll-free within the United States
(609) 452-8570 Collect outside the United States

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

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

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

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

Insured Person's Right to an External Appeal

An Insured Person or an Insured's representative and, in connection with a Retrospective Adverse Determination, an Insured's Physician have a right to an external appeal of a denial of benefits. If benefits are denied under this policy on the basis that the service is not a Medical Necessity or is an experimental or investigational treatment, an Insured Person or his representative and, in connection with a Retrospective Adverse Determination, an Insured'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.

A Retrospective Adverse Determination is a determination for which utilization review was initiated after health care services have been provided. Retrospective Adverse Determination does not mean a pre-authorization denial or a determination involving continued or extended health care services or additional services for a patient undergoing a course of continued treatment.

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

If benefits are denied under this policy on the basis that the service is not a Medical Necessity, an Insured Person may appeal to an External Appeal Agent if the Insured Person satisfies the following two (2) criteria:

1. The service, procedure or treatment must otherwise be a Covered Medical Expense under this policy; and
2. 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 or the Insured Person and the Company must agree in writing to waive any internal appeal.

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

If benefits are denied under this policy on the basis that the service is an experimental or investigational treatment, an Insured Person may appeal to an External Appeal Agent if the Insured Person satisfies the following two (2) criteria:

1. The service must otherwise be a Covered Medical Expense under this policy; and
2. 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 or the Insured Person and the Company must agree in writing to waive any internal appeal.

In addition, the Insured Person's attending Physician must certify that the Insured Person has a Life-Threatening or Disabling Condition or Disease. A "life-threatening condition or disease" is one which, according to the current diagnosis of the Insured Person's attending Physician, has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders the Insured Person unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The Insured Person's attending Physician must also certify that the Insured Person's Life-Threatening or Disabling Condition or Disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by this policy or one for which there exists a clinical trial (as defined by law).

In addition, the Insured Person's attending Physician must have recommended one of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the Insured Person than any standard covered service (only certain documents will be considered in support of this recommendation - the Insured Person's attending Physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable); or
2. A clinical trial for which the Insured Person is eligible (only certain clinical trials can be considered).

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 Life-Threatening or Disabling Condition or Disease.

The External Appeal Process

If, through the Company's internal appeal process, the Insured Person has received 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 45 days 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 45 days from receipt of such waiver to file a written request for an external appeal. The Company will provide an external appeal application with the 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 Insurance at 1 - (800) 400-8882. The completed application should be submitted to the New York State Department of Insurance 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 Insurance 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, his 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 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, the Insured Person may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three (3) days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the Insured Person 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, this 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 $50 for an external appeal. The external appeal application will instruct the Insured Person on the manner in which he must submit the fee. The Company will also waive the fee if the Company determines that paying the fee would pose a hardship to the Insured Person. If the External Appeal Agent overturns the denial of benefits, the fee shall be refunded to the Insured Person.

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

It is the Insured Person's or, for appeal of a Retrospective Adverse Determination, the Insured's Physician's responsibility to 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 Insurance (For Insureds, New York State External Appeal Application for Health Care Consumers; for Physicians, New York State External Appeal Application for Health Care Providers). 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 45 days 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. The Company has no authority to grant an extension of this deadline.

Online Access to Account Information

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

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

Claim Procedure

In the event of Injury or Sickness, the students should:

1. Report to the Student Health Center or Infirmary for treatment or referral 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 the name of the association (ACSA) 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, TX 75380-9025
1-800-505-5450
Claims@uhcsr.com
Customerservice@uhcsr.com

Sales/Marketing Service:

UnitedHealthcare StudentResources
E-mail: info@uhcsr.com
Website: www.uhcsr.com

Online Services:

Please visit our Website at www.ACSA.com for Brochures, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services or you can e-mail us your questions at info@ACSA.com.

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at ACSA 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 Numbers 2011-2101-30 (High Option, Plan I) & 2011-2101-31 (Low Option, Plan II)