

2009-2010

STUDENT INJURY AND SICKNESS
INSURANCE PLAN

Designed Especially for the Students of

**Binghamton
University**

**Limited Benefit Plan.
Please Read Carefully.**

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



IMPORTANT INFORMATION ABOUT STUDENT ACCIDENT & SICKNESS INSURANCE

Dear Students and Parents:

I am pleased to announce an excellent Student Accident and Sickness Insurance Plan, which is available to all students in the coming academic year.

The student insurance plan supplements services provided by the University Health Service and should NOT be confused with the health fee. Insurance helps to pay for medical care bills from OFF CAMPUS providers and is required of full-time undergraduate students, unless proof of alternate coverage is provided to the Office of Student Accounts by the end of the sixth week of classes each semester. The plan is optional for part-time and graduate students. This plan covers eligible Expenses up to \$25,000 per Injury or Sickness with a small Deductible. This brochure provides a full description of coverage, including cost, benefits, exclusions, any reductions and limitations, and the terms under which the coverage may remain in force. The students are covered anywhere in the world.

You may wish to consider the following even if You have other coverage:

- Your current insurance may not cover the types of Expenses most frequently incurred by college age individuals, such as outpatient referrals, or may cover them only after a Deductible or copayment. This Plan helps cover those Expenses. It may be used to supplement or complement a family plan.
- If Your current insurance is through an HMO or preferred provider network out of the Binghamton area, services locally may be limited or charged to You at a higher, non-preferred rate. Many students have found it challenging to use their HMO coverage in the Binghamton health care market.
- Coverage through parents' policies may end on a student's birthday (i.e. at age 19, 23 or 25).
- Coverage is available for eligible dependent children and spouses.

You are welcome to speak with my staff at (607)-777-2221 about how this plan complements the care offered to all students at the University Health Service or Niagara National, Inc. at (800)-444-5530 with questions about the Plan.

Sincerely,

Johann M. Fiore-Conte
Director of Health & Counseling Services, University Health Service

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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 1-800-767-0700 or visiting us at www.uhcsr.com.

Eligibility

All domestic undergraduate students are automatically enrolled in this insurance Plan. Students enrolled for a minimum of 11 or more credits may waive out of this insurance if able to provide proof of comparable coverage. Part time undergraduate students may waive out without proof of comparable coverage. Graduate students are eligible to participate on a voluntary basis.

All Insured students may purchase Supplemental 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, Internet and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. **If the Company discovers that the Policy Eligibility requirements have not been met, its only obligation is to refund premium.**

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the spouse and unmarried children under 19 years of age. 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 may purchase Optional Supplemental Medical coverage.

Waiver Deadline:

If you have proof of comparable insurance and wish to waive coverage, the deadline to waive out of this plan is 10/03/2009. For students beginning their studies in the spring, the deadline is 03/06/2010.

Effective and Termination Dates

The Master Policy on file at the school becomes effective August 15, 2009. 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 August 14, 2010. 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 or extend beyond that of the Insured.

Premium Rates and Expiration Dates

If paying premiums by any payment period other than annual, coverage expires as follows:

	Annual	Fall	Spring	Summer
	8/15/09-8/14/10	08/15/09-01/15/10	1/16/10-8/14/10	5/15/10-8/14/10
Student	\$568.00	\$237.00	\$331.00	\$143.00
Spouse	\$767.00	\$324.00	\$443.00	\$193.00
Each Child	\$767.00	\$324.00	\$443.00	\$193.00

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

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 31 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

Avidyn 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.

Avidyn 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
Up To \$25,000 Maximum Benefit As Specified Below (For Each Injury or Sickness)
Deductible - \$50 (For Each Injury or Sickness)**

*(The \$50 Deductible will be reduced to \$25 if referred by the Student Health Center)
Coinsurance - 100% except as noted below*

UnitedHealthcare Options PPO Network Physician's and Hospitals have agreed to accept special reimbursement rates for treatment rendered to Insureds; therefore, use of UnitedHealthcare Options PPO Network may result in lower out of pocket expenses. All benefits payable for Covered Medical Expenses are subject to the coinsurance noted above and the maximum benefits for each service specified below in the Schedule of Benefits.

The Company will pay 100% of Usual & Customary Charges for Covered Medical Expenses up to \$1,000 after the Deductible of \$50 Per Injury or Sickness has been satisfied. After the Company has paid \$1,000, payment will be decreased to 80% of Usual & Customary Charges for additional Covered Medical Expenses up to \$5,000. After the Company has paid \$5,000, payment will be increased to 100% of Usual & Customary Charges for additional Covered Medical Expenses up to a combined maximum of \$25,000 for each Injury or Sickness.

Students should first seek treatment at Student Health Services. Prescription Drugs for allergy and acne treatments are covered at the SHC only. Immunizations and HPV vaccine are covered at the SHC only.

Usual and Customary Charges are based on data provided by Ingenix using the 90th percentile based on locality where service is rendered.

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

Maximum - max	Usual & Customary - U&C
INPATIENT	
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 test, 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.	U&C
Routine Newborn Care , while Hospital Confined; and routine nursery care provided immediately after birth.	See Benefits for Maternity Expenses
Physiotherapy	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, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	U&C
Assistant Surgeon	U&C
Anesthetist , professional services in connection with inpatient surgery.	U&C
Registered Nurse's Services , private duty nursing care.	U&C

INPATIENT	
Physician's Visits , benefits are limited to one visit per day and do not apply when related to surgery.	U&C
Pre-admission Testing , payable within 3 working days prior to admission.	Paid under Hospital Expense
Psychotherapy , benefits are limited to one visit per day.	See Benefits for Mental and Nervous Disorder 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 Ingenix. If two or more procedures are performed through the same incision or in immediate succession, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	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.	U&C
Assistant Surgeon	U&C
Anesthetist , professional services administered in connection with outpatient surgery.	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.	U&C
Physiotherapy , all chiropractic care is payable under Physician's Visits.	Paid under Physician's Visits
Medical Emergency Expenses , use of emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.	U&C
Diagnostic X-ray and Laboratory Services , (Includes Ultrasound, MRI, CAT Scan, Mammography, Chlamydia, Gonorrhea, STD and HIV Testing/Screening.)	U&C
Radiation Therapy & Chemotherapy	U&C
Tests & Procedures , diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures.	Paid under Diagnostic X-rays and Laboratory Services
Injections	No Benefits

OUTPATIENT	
Prescription Drugs	U&C / \$5 Deductible per prescription / \$1,500 max
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	U&C
Durable Medical Equipment , a written prescription must accompany the claim when submitted. Replacement equipment is not covered.	U&C
Consultant Physician Fees , when requested and approved by the attending Physician.	U&C / \$100 max
Dental , made necessary by Injury to Sound, Natural Teeth.	U&C
Chemical Dependence (Alcoholism/Drug Abuse)	See Benefits for Chemical Dependence (Alcoholism/Drug Abuse)
Maternity	See Benefits for Maternity Expenses
Elective Abortion	U&C / \$250 max
Complications of Pregnancy	Paid as any other Sickness
Routine Well Baby Care (<i>Benefits include Well Baby Physician's Visits and immunizations for the first year.</i>)	U&C
Home Health Care	75% of U&C / \$50 Deductible / 40 visits max
Second Surgical Opinion	U&C
Annual Routine Physical Exam (<i>Immunizations including HPV (Gardasil) are only covered at the SHC.</i>)	U&C

Optional Supplemental Medical Benefit \$225,000 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 Optional Supplemental Medical Benefit begins payment after the Basic Maximum Benefit of \$25,000 has been paid by the Company.

The Company will pay 80% for additional Covered Medical Expenses incurred up to the Optional Supplemental Medical Maximum of \$225,000.

The total benefits payable under Optional Supplemental Medical is \$250,000 minus the Basic Benefit already paid.

No benefits will be paid under Optional Supplemental Medical for:

1. Room and board expenses which exceed the semi-private room rate;
2. Services designated as "No Benefits" in the Basic Medical Expense Benefits Schedule of Benefits; or
3. Pre-existing Conditions; except for individuals who have been continuously insured under Optional Supplemental Medical coverage for at least 12 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 continuous to a date not more than 63 days prior to the Insured's enrollment date under Optional Supplemental Medical Coverage.

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. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: Amniocentesis/AFP Screening and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

Excess Provision

No benefits are payable for any expense incurred for Injury or Sickness which has been paid or is payable by other valid and collectible insurance or under an automobile insurance policy.

However, this Excess Provision will not be applied to the first \$100 Medical Expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed as a result of the Insured's failure to comply with policy provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

Continuation Privilege

All Insured Persons who have been continuously insured under the school's regular student Policy for at least 6 months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 6 months under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

Application must be made and premium must be paid directly to **StudentResources** and be received within 14 days after the expiration date of your student coverage. For further information on the Continuation privilege, please contact UnitedHealthcare at 1-800-767-0700.

Mandated Benefits

Benefits for Maternity Expenses

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

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

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

Benefits will be paid for:

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

In the event the mother chooses an earlier discharge, at least one home visit will be available to the mother, and not subject to any 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 Diabetes Expenses

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

- (a) lancets and automatic lancing devices;
- (b) glucose test strips;
- (c) blood glucose monitors;
- (d) blood glucose monitors for the visually impaired;
- (e) control solutions used in blood glucose monitors;
- (f) diabetes data management systems for management of blood glucose;
- (g) urine testing products for glucose and ketones;
- (h) oral 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 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 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 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; gastroesophageal 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 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 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 health, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

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

- (a) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- (b) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
- (c) on a prescribed drug regimen posing a significant risk of osteoporosis; or
- (d) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
- (e) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

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

Benefits for Mental 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 purposes 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.

Benefits for Contraceptive Drugs or Devices

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

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

Definitions

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

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 of the Policyholder. 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. Chemical Dependence (Alcoholism/Drug Abuse), except as specifically provided in Benefits for Chemical Dependence (Alcoholism/Drug Abuse);
2. 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;

3. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;
4. Dental treatment, except for accidental Injury to Sound, Natural Teeth; or due to a congenital disease or anomaly;
5. Elective Surgery or Elective Treatment;
6. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses. Vision correction, or other treatment for visual defects and problems; except when due to a disease process or a Medical Necessity;
7. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
8. Hearing examinations 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;
9. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
10. Injury or Sickness outside the United States and its possessions, Canada or Mexico, except for a Medical Emergency when traveling for academic study abroad programs, business or pleasure;
11. Injury sustained while (a) participating in any interscholastic sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
12. Investigational services or experimental treatment, except for experimental or investigational treatment approved by an External Appeal Agent in accordance with Insured Persons Right to an External Appeal. If the External Appeal Agent approves benefits of an experimental or investigational treatment that is part of a clinical trial, this policy will only cover the costs of services required to provide treatment to the Insured according to the design of the trial. The Company shall not be responsible for the cost of investigational drugs or devices, the costs of non-health 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. Marital or family counseling;
14. Participation in a felony, riot or insurrection;
15. Pre-existing Conditions, except for individuals who have been continuously insured under the school's student insurance policy for at least 12 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, except as specifically provided in the policy:
 - 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; or chartered aircraft only while participating in a school sponsored interscholastic sport activity;
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 and health information 24 hours a day, 7 days a week by dialing 1-877-643-5130. The Collegiate Assistance Program is staffed by Registered Nurses who can help students determine if they need to seek medical care, understand their medications or medical procedures, or learn ways to stay healthy.

Scholastic Emergency Services: Global Emergency Medical Assistance

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

Domestic Students, insured spouse 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 U.S. State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, any services not arranged by SES will not be considered for payment.

Key Services include:

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

Please visit your school's insurance coverage page at www.uhcsr.com for the SES Global Emergency Assistance Services brochure which includes 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 Scholastic 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. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure for Program Guidelines as well as 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 **StudentResources** 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.

Claims Procedure

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

1. Report to the Student Health Service for treatment, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and Hospital bills, along with the patient's name and Insured Student's name, address, social security number and the name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 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

1-800-767-0700

claims@uhcsr.com

customerservice@uhcsr.com

Niagara National, Inc

5001 Genesee Street

Buffalo, NY 14225

(800) 444-5530

(716) 684-6285 fax

www.niagaranational.com

EMAIL: nninfo@niagaranational.com

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