

UNITED HEALTHCARE INSURANCE COMPANY

Administrative Office Address: P.O. Box 809025, Dallas, TX 75380-9025

POLICYHOLDER	SOMA STUDENT OSTEOPATHIC MEDICAL ASSOCIATION	POLICY NUMBER	2009-200408-6
ADDRESS	142 EAST ONTARIO STREET CHICAGO, ILLINOIS 60611	Effective Date	2009-2010 ACADEMIC YEAR
		Termination Date	2009-2010 ACADEMIC YEAR

PREMIUM FOR EACH INSURED PERSON

SEE APPLICATION ATTACHED

LIST OF ENDORSEMENTS ATTACHED TO AND FORMING A PART OF THIS POLICY

COL-06MOR-NY (1) (Rev 07-07)
COL-06-NY END (5A)
COL-06-NY END (6A)
COL-06-END (7)
COL-06-IL END (RX)

UNITED HEALTHCARE INSURANCE COMPANY

hereinafter called the Company, agrees, subject to all provisions, conditions, exclusions and limitations of this policy to pay the benefits provided by this policy for loss resulting from a cause covered by this policy. This policy is issued in consideration of the application and payment of the premiums. Premiums as specified above are payable for each Insured Person.

Non-Renewable One Year Term Insurance -- This Policy Will Not Be Renewed



President

Countersigned by _____ Licensed Resident
Agent

PREMIUMS AND PREMIUM PAYMENT

The Policyholder agrees to remit the premium for each Insured Person to the Company or its authorized agent within 20 days after the receipt of the premium. The Company will have the right to examine all of the Policyholder's books and records relating to this policy at any time up to the later of 1) two years after the termination of this policy and 2) the date of final adjustment and settlement of all claims under this policy.

TABLE OF CONTENTS

Eligibility and Termination Provisions	2
General Provisions	3
Definitions	4
Schedule of Benefits	9
Benefit Provisions	10
Mandated Benefits	13
Exclusions and Limitations	18
Right to an External Appeal	20

PART I
ELIGIBILITY AND TERMINATION PROVISIONS

Eligibility: Each person who belongs to one of the "Classes of Persons To Be Insured" as set forth in the application is eligible to be insured under this policy. The Named Insured 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 Named Insured 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 and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium.

The eligibility date for Dependents of the Named Insured (as defined) shall be determined in accordance with the following:

- 1) If a Named Insured has Dependents on the date he or she is eligible for insurance; or
- 2) If a Named Insured acquires a Dependent after the Effective Date, such Dependent becomes eligible:
 - (a) On the date the Named Insured marries the Dependent; or
 - (b) On the date the Named Insured acquires a dependent child who is within the limits of a dependent, unmarried child set forth in the "Definitions" section of this policy.

Dependent eligibility expires concurrently with that of the Named Insured.

Eligible persons may be insured under this policy subject to the following:

- 1) Payment of premium as set forth on the policy application; and,
- 2) Application to the Company for such coverage.

Effective Date: Insurance under this policy shall become effective on the later of the following dates:

- 1) The Effective Date of the policy; or
- 2) The date premium is received by the Administrator.

Dependent coverage will not be effective prior to that of the Named Insured.

Termination Date: The coverage provided with respect to the Named Insured shall terminate on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid; or
- 2) The date the policy terminates.

The coverage provided with respect to any Dependent shall terminate on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid;
- 2) The date the policy terminates; or
- 3) The date the Named Insured's coverage terminates.

PART II
GENERAL PROVISIONS

STATEMENTS; ENTIRE CONTRACT; CHANGES: No statement made by an Insured Person shall avoid the insurance or reduce benefits there under unless contained in a written instrument signed by the Insured Person. All statements contained in any such written instrument shall be deemed representations and not warranties. This policy, including the endorsements and attached papers, if any, and the application of the Policyholder shall constitute the entire contract between the parties. No agent has authority to change this policy or to waive any of its provisions. No change in the policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. Such an endorsement or attachment shall be effective without the consent of the Insured Person but shall be without prejudice to any claim arising prior to its Effective Date.

GENERAL PROVISIONS (Continued)

PAYMENT OF PREMIUM: All premiums are payable in advance for each policy term in accordance with the Company's premium rates. The full premium must be paid even if the premium is received after the policy Effective Date. There is no pro-rata or reduced premium payment for late enrollees. There will be no refunds to students who cancel coverage under the policy; unless the Insured enters the armed forces.

Premium adjustments involving return of unearned premiums to the Policyholder will be limited to a period of 12 months immediately preceding the date of receipt by the Company of evidence that adjustments should be made. Premiums are payable to the Company.

ISSUANCE OF CERTIFICATES: The company will issue, either to the Policyholder or directly to the Named Insured, a certificate setting forth in summary form a statement of the essential features and substance of the provisions of the insurance coverage.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company with information sufficient to identify the Named Insured shall be deemed notice to the Company.

CLAIM FORMS: Claim forms are not required.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof and that notice was given as soon as was reasonably possible.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid upon receipt of due written proof of such loss.

PAYMENT OF CLAIMS: All benefits are payable to the Insured. If the Insured is a minor, such benefits may be made payable to his or her parent or legal guardian. A loss of life benefit, if any, will be paid in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, that benefit shall be paid to the estate of the Insured Person. Any other benefits unpaid at the death of the Insured Person may, at the Company's option, be paid to the beneficiary (other than the Policyholder or an officer of the Policyholder as such) or the Insured Person's estate. Subject to any written direction of the Insured, all or a portion of any indemnities provided by this policy may be paid directly to the Hospital, Physician or person rendering such service or treatment. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

PHYSICAL EXAMINATION: As a part of Proof of Loss, the Company at its own expense shall have the right and opportunity: 1) to examine the person of any Insured Person when and as often as it may reasonably require during the pendency of a claim; and, 2) to have an autopsy made in case of death where it is not forbidden by law. The Company has the right to secure a second opinion regarding treatment or hospitalization. Failure of an Insured to present himself or herself for examination by a Physician when requested shall authorize the Company to: (1) withhold any payment of Covered Medical Expenses until such examination is performed and Physician's report received; and (2) deduct from any amounts otherwise payable hereunder any amount for which the Company has become obligated to pay to a Physician retained by the Company to make an examination for which the Insured failed to appear. Said deduction shall be made with the same force and effect as a Deductible herein defined.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 2 years after the time written proof of loss are required to be furnished.

SUBROGATION: When benefits are paid to or for an Insured under the terms of this policy, the Company shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured for Hospital, medical, or surgical services and benefits. The right of subrogation will only be exercised by the Company when the amounts (or portion) received by the Insured through a third-party settlement or satisfied judgment is specifically identified as amounts paid for Hospital, medical or surgical services and benefits. Such subrogation rights shall extend only to the recovery by the Company of the benefits it has paid for such hospitalization and treatment. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

GENERAL PROVISIONS (Continued)

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

PART III DEFINITIONS

COMPLICATION OF PREGNANCY means: 1) conditions requiring Hospital stays (when the pregnancy is not terminated whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, and will not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) nonelective caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

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

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

CREDITABLE COVERAGE means coverage under any of the following:

- (a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
- (b) The federal Medicare Program pursuant to Title XVIII of the Social Security Act;
- (c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- (d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
- (e) a medical care program of the Indian Health Service or of a tribal organization;
- (f) a state health benefits risk pool;
- (g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
- (h) a public health plan as defined by federal regulations; or
- (i) a health benefit plan under section 5(e) of the Peace Corps Act.

CUSTODIAL CARE means help in transferring, eating, dressing, bathing, toileting, and other such related services.

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

DEFINITIONS (Continued)

DEPENDENT means the spouse (husband or wife) or Domestic Partner of the Named Insured and their dependent, unmarried children including legally adopted children, a child placed with the Insured pending adoption procedures, unless the child is removed from placement with the Insured prior to final adoption, and step-children. Children shall cease to be dependent on the first to occur of:

- 1) The end of the month in which they marry; or,
- 2) The end of the month in which they attain the age of nineteen (19) years.

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

- 1) Incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation or physical handicap; and,
- 2) Chiefly dependent upon the Insured Person for support and maintenance.

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

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

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.

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

HOSPITAL means a short-term, acute, general hospital, which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; 6) if located in New York state, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395xk0; and 7) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, education, or rehabilitatory care.

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

DEFINITIONS (Continued)

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

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

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

- 1) Progressive care;
- 2) Sub-acute intensive care;
- 3) Intermediate care units;
- 4) Private monitored rooms;
- 5) Observation units; or
- 6) Other facilities which do not meet the standards for intensive care.

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

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

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

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

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

The Medical Necessity of being Hospital Confined means that: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

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

DEFINITIONS (Continued)

MENTAL AND NERVOUS DISORDER means medically necessary mental health care rendered by an eligible practitioner or approved facility and which, in the opinion of the Company, is directed predominantly at treatable behavioral manifestations of a condition that the Company determines (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) had been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

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

NEWBORN INFANT means: 1) any newly born child of an Insured provided that the person is insured under this policy; 2) a newborn adopted child of an Insured provided the person is insured under this policy on the date the adoption is effective; and 3) a newborn child placed with the Insured pending adoption procedures provided the person adopting the child is insured under the policy on the date the child is placed with the Insured. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

PHYSICIAN means a legally qualified licensed practitioner of the healing arts, including a chiropractor, who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

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

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.

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

PSYCHOTHERAPY means Mental and Nervous Disorder Treatment

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

SICKNESS means sickness or disease of the Insured Person which causes loss, 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.

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

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality 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.

PART IV
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.

PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
SOMA - STUDENT OSTEOPATHIC MEDICAL ASSOC - SAVER PLAN - NY
2009-200408-6
INJURY AND SICKNESS BENEFITS

Maximum Benefit	\$100,000 (For each Injury or Sickness)
Deductible Preferred Providers	\$250 (Per Insured Person)(Per Policy Year)
Deductible Out of Network	\$500 (Per Insured Person)(Per Policy Year)
Coinsurance Preferred Providers	80% except as noted below
Coinsurance Out of Network	60% except as noted below

(New Students with an effective date in June, July, or August with expenses incurred during the last 3 months of the Policy Year which are applied against the Policy Year's Deductible will also be applied towards the Deductible for the next Policy Year and thus reduce or eliminated that Policy Year's Deductible.)

The Preferred Provider for this plan is United Healthcare Options PPO.

Policy Exception: Benefits for pap tests paid under the Benefits for Cervical Cytological Screenings will not be subject to the Deductible.

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.

Needle Stick / Face Splash as a result of course work will be paid as any other Injury or Sickness.

There is a \$9,750 out of pocket maximum .Once the insured's out of pocket has reached \$9,750 in Covered Medical Expenses, the Company will pay additional Covered Medical Expenses at 100% of Preferred Allowance for Preferred Providers and 100% of Usual & Customary Out-of-Network. The out of pocket maximum does not include per service benefit Deductibles. Per service maximums still apply.

The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. 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.

Inpatient	Preferred Providers	Out of Network
Room & Board/Hosp Misc: <i>(\$1,500 Aggregate Maximum per day.)</i>	Preferred Allowance	Usual & Customary Charges
Intensive Care:	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
Routine Newborn Care:	See Benefits for Maternity Expenses	See Benefits for Maternity Expenses
Physiotherapy:	Paid under Room & Board/Hospital Misc.	Paid under Room & Board/Hospital Misc.
Surgery: <i>(Specified surgery based on data provided by Ingenix.)</i>	Preferred Allowance	Usual & Customary Charges
Assistant Surgeon: <i>(Includes benefits for secondary Assistant Surgeon's Fees at 50% of the primary Assistant Surgeon Fee Allowance.)</i>	Preferred Allowance	Usual & Customary Charges
Anesthetist:	25% of Surgery Allowance	25% of Surgery Allowance
Registered Nurse's Services:	Preferred Allowance	Usual & Customary Charges
Physician's Visits:	Preferred Allowance	Usual & Customary Charges
Pre-admission Testing: <i>(\$1,500 maximum)</i>	Preferred Allowance	Usual & Customary Charges
Psychotherapy:	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
SOMA - STUDENT OSTEOPATHIC MEDICAL ASSOC - SAVER PLAN - NY
2009-200408-6
INJURY AND SICKNESS BENEFITS

Outpatient	Preferred Providers	Out of Network
Surgery: <i>(Specified surgery based on data provided by Ingenix.)</i>	Preferred Allowance	Usual & Customary Charges
Day Surgery Miscellaneous: <i>(\$1,500 maximum) (Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</i>	Preferred Allowance	Usual & Customary Charges
Assistant Surgeon: <i>(Includes benefits for secondary Assistant Surgeon Fees at 50% of the primary Assistant Surgeon Fee allowance.)</i>	Preferred Allowance	Usual & Customary Charges
Anesthetist:	25% of Surgery Allowance	25% of Surgery Allowance
Outpatient Miscellaneous Benefit: <i>(\$2,000 maximum)</i>	Preferred Allowance	Usual & Customary Charges
Physician's Visits: <i>(\$25 copay/ Deductible per visit.)</i>	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous Benefit
Physiotherapy: <i>(\$50 per visit / 10 visit maximum. All Chiropractic care is payable under Physician's Visits.)</i>	Preferred Allowance	Usual & Customary Charges
Medical Emergency:	80% of Preferred Allowance	80% of Usual & Customary Charges
Diagnostic X-rays & Laboratory:	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous Benefit
Radiation Therapy:	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous Benefit
Tests & Procedures:	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous Benefit
Injections: <i>(\$1,500 maximum)</i>	Preferred Allowance	Usual & Customary Charges
Chemotherapy:	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous Benefit
*Prescription Drugs: <i>(Preferred Providers - Policy Deductible does not apply)(Mail order Prescription Drugs through UHPS at 2.5 times the retail copay up to a 90 day Supply)</i>	Prescriptions must be filled at a UnitedHealthcare Network Pharmacy (UHPS) / \$15 copay per prescription for Tier 1 / \$25 copay per prescription for Tier 2 / up to a 31-day supply per prescription / \$600 maximum (Per Policy Year)	No Benefits - Prescriptions are only covered if filled at a United Healthcare Network Pharmacy
Psychotherapy:	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances	See Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances

SCHEDULE OF BENEFITS (continued)
MEDICAL EXPENSE BENEFITS
SOMA - STUDENT OSTEOPATHIC MEDICAL ASSOC - SAVER PLAN - NY
2009-200408-6
INJURY AND SICKNESS BENEFITS

Other	Preferred Providers	Out of Network
Ambulance: <i>(\$200 maximum per Injury or Sickness.)</i>	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Durable Medical Equipment: <i>(\$1,500 maximum)</i>	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Consultant:	Preferred Allowance	Usual & Customary Charges
Dental: <i>(\$500 maximum. Benefits for Injury to Sound, Natural teeth.)</i>	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Chemical Dependence: (Alcoholism/Drug Abuse)	See Benefits for Chemical Dependence (Alcoholism/Drug Abuse)	See Benefits for Chemical Dependence (Alcoholism/Drug Abuse)
Maternity:	See Benefits for Maternity Expenses	See Benefits for Maternity Expenses
Elective Abortion:	No Benefits	No Benefits
Complications of Pregnancy:	Paid as any other Sickness	Paid as any other Sickness
Repatriation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
Medical Evacuation:	Benefits provided by Scholastic Emergency Services, Inc.	Benefits provided by Scholastic Emergency Services, Inc.
AD&D:	\$5,000 - \$10,000 maximum	\$5,000 - \$10,000 maximum
Interscholastic Sports:	No Benefits	No Benefits
Home Health Care:	Preferred Allowance	Usual & Customary Charges
CAT Scan/MRI:	Paid under Outpatient Miscellaneous Benefit	Paid under Outpatient Miscellaneous Benefit
Wellness Benefit <i>(Benefits for the Insured and Dependents over the age of 18. Benefits include one examination/routine physical and one HIV/syphilis test each Policy Year, includes pre/post test counseling. For men, routine physical examination includes the office visit charge and a gonorrhea/chlamydia test, hemoglobin and urine test. For women, examination includes the office visit charge, gonorrhea, chlamydia test, hemcult for women over the age of 50, a hemoglobin and urine test. (Not subject to the policy year deductible.) (\$150 maximum)</i>	Usual & Customary Charges	Usual & Customary Charges

SUPPLEMENTAL MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

SHC Referral Required: Yes () No (X)

() 52 week Benefit Period or (X) Extension of Benefits

***Pre-Admission Notification:** Yes (X) No ()

Other Insurance: (X) *Excess Insurance () Primary Insurance

*If benefit is designated, see endorsement attached.

SCHEDULE OF BENEFITS (Continued)
MEDICAL EXPENSE BENEFITS
SOMA - STUDENT OSTEOPATHIC MEDICAL ASSOC - SAVER PLAN - NY
2009-200408-6
INJURY AND SICKNESS BENEFITS

PREFERRED PROVIDER INFORMATION

“Preferred Providers” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. The Preferred Provider in the local school area is:

UnitedHealthcare Options PPO

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

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

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

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

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at the coinsurance specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Call (800) 767-0700 for information about Preferred Hospitals.

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

Outpatient Hospital Expenses

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

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Option PPO will be paid at the coinsurance specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

PART VI
MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the Maximum Benefit for all services; b) the maximum amount for specific services; both as set forth in the Schedule of Benefits; and c) any coinsurance amount set forth in the Schedule of Benefits or any endorsement hereto. The total payable for all Covered Medical Expenses shall never exceed the Maximum Benefit stated in the Schedule of Benefits. **Read the "Definitions" section and the "Exclusions and Limitations" section carefully.**

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

1. **Room and Board Expense:** 1) daily semi-private room rate when Hospital Confined; and 2) general nursing care provided and charged by the Hospital.
2. **Intensive Care:** If provided in the Schedule of Benefits.
3. **Hospital Miscellaneous Expenses:** 1) while Hospital Confined; or 2) as a precondition for being Hospital Confined. Benefits will be paid for services and supplies 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.
4. **Routine Newborn Care:** The benefits and the maximum amounts are specified in Benefits for Maternity Expenses.
5. **Physiotherapy (Inpatient):** See Schedule of Benefits.
6. **Surgery:** Physician's fees for inpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. 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.
7. **Assistant Surgeon Fees:** in connection with inpatient surgery, if provided in the Schedule of Benefits.
8. **Anesthetist Services:** professional services administered in connection with inpatient surgery.
9. **Registered Nurse's Services:** 1) private duty nursing care only; 2) while Hospital Confined; 3) ordered by a licensed Physician; and 4) a Medical Necessity. General nursing care provided by the Hospital is not covered under this benefit.
10. **Physician's Visits:** when Hospital Confined. Benefits are limited to one visit per day. Benefits do not apply when related to surgery. Covered Medical Expenses will be paid under the inpatient benefit or under the outpatient benefit for Physician's Visits, but not both on the same day.
11. **Pre-admission Testing:** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the "Hospital Miscellaneous" benefit. This benefit is payable within 3 working days prior to admission.
12. **Psychotherapy (Inpatient):** the benefits and the maximum amounts are specified in the Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances. Benefits are limited to one visit per day.

MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS (Continued)

13. **Surgery (Outpatient):** Physician's fees for outpatient surgery. Payment will be made based upon the surgical schedule as specified in the Schedule of Benefits. 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.
14. **Day Surgery Miscellaneous (Outpatient):** in connection with outpatient day surgery; excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic. Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; therapeutic services; and supplies.
15. **Assistant Surgeon Fees (Outpatient):** in connection with outpatient surgery, if provided in the Schedule of Benefits.
16. **Anesthetist (Outpatient):** professional services administered in connection with outpatient surgery.
17. **Outpatient Miscellaneous Benefit:** outpatient Hospital and Physician services. Outpatient services payable under this benefit will be designated "Paid under Outpatient Miscellaneous Benefit" in the Schedule of Benefits.
18. **Physician's Visits (Outpatient):** Benefits apply to chiropractic care. Benefits are limited to one visit per day. Benefits do not apply when related to surgery or Physiotherapy. Covered Medical Expenses will be paid under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.
19. **Physiotherapy (Outpatient):** benefits are limited to one visit per day.
20. **Medical Emergency Expenses (Outpatient):** only in connection with a Medical Emergency as defined. Benefits will be paid for the use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.
21. **Diagnostic X-ray Services (Outpatient):** if so noted in the Schedule of Benefits. Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive.
22. **Radiation Therapy (Outpatient):** See Schedule of Benefits.
23. **Laboratory Procedures (Outpatient):** Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.
24. **Tests and Procedures (Outpatient):** 1) diagnostic services and medical procedures; 2) performed by a Physician; 3) excluding Physician's Visits; Physiotherapy; X-Rays; and Laboratory Procedures.
25. **Injections (Outpatient):** 1) when administered in the Physician's office; and 2) charged on the Physician's statement.
26. **Chemotherapy (Outpatient):** See Schedule of Benefits.
27. **Prescription Drugs (Outpatient):** See Schedule of Benefits.
28. **Psychotherapy (Outpatient):** the benefits and the maximum amounts are specified in the Benefits for Mental and Nervous Disorder Treatment, Benefits for Biologically Based Mental Illness and Benefits for Children with Serious Emotional Disturbances. Benefits are limited to one visit per day.
29. **Ambulance Services:** See Schedule of Benefits.

MEDICAL EXPENSE BENEFITS - INJURY AND SICKNESS (Continued)

30. **Durable Medical Equipment:** 1) when prescribed by a Physician; and 2) a written prescription accompanies the claim when submitted. Replacements are never covered. Durable medical equipment includes equipment that: 1) is primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price.
31. **Consultant Physician Fees:** when requested and approved by the attending Physician.
32. **Dental Treatment:** 1) performed by a Physician; and, 2) made necessary by Injury to Sound, Natural Teeth. Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered.
33. **Chemical Dependence (Alcoholism/Drug Abuse):** the benefits and the maximum amounts are specified in Benefits for Chemical Dependence (Alcoholism/Drug Abuse).
34. **Maternity:** See Benefits for Maternity Expenses.
35. **Complications of Pregnancy:** Same as any other Sickness.
36. **Repatriation:** if the Insured dies while insured under the policy; benefits will be paid for: 1) preparing; and 2) transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Supplemental Medical coverage.
37. **Medical Evacuation:** 1) when Hospital Confined for at least five consecutive days; and 2) when recommended and approved by the attending Physician. Benefits will be paid for the evacuation of the Insured to his home country. This benefit is limited to the maximum benefit specified in the Schedule of Benefits. No additional benefits will be paid under Basic or Supplemental Medical coverage.
38. **Supplemental Injury Benefit:** for treatment rendered: 1) on an inpatient or outpatient basis; 2) in a Physician's office or Hospital; and 3) as a result of Injury. This benefit will be paid prior to all other Basic benefits.
39. **Accidental Death and Dismemberment:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.
40. **Interscholastic Sports:** the benefits and the maximum amounts are specified in the Schedule of Benefits and endorsement attached hereto, if so noted in the Schedule of Benefits.

**PART VII
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 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 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 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; 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 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 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 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.

**PART VIII
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. Dental treatment, except for accidental Injury to Sound, Natural Teeth or due to congenital disease or anomaly;
4. Elective Surgery or Elective Treatment;
5. Elective abortion;
6. Eye examinations, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses. Vision correction, or other treatment for visual defects and problems; except when due to a disease process or a Medical Necessity;
7. 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;
8. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
9. 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;
10. Participation in a felony, riot or insurrection;
11. Pre-existing Conditions, except for individuals who have been continuously insured under the SOMA 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;
12. 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;
13. Preventive medicines, serums, vaccines or immunizations, except as specifically provided in the policy;
14. Routine Newborn Infant Care, well-baby nursery and Physician charges, except as specifically provided in the Benefits for Maternity Expense;
15. Services provided normally without charge by the Student Health Center of the Policyholder; or services covered or provided by the student health fee;

EXCLUSIONS AND LIMITATIONS (Continued)

16. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
17. Suicide or attempted suicide or intentionally self-inflicted Injury;
18. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
19. Treatment, service or supply which is not a Medical Necessity; subject to Article 49 of N.Y. Insurance Law;
20. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

PART IX
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.

INSURED PERSON'S RIGHT TO AN EXTERNAL APPEAL (Continued)

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.

POLICY RIDER

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this rider is attached is amended as follows:

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.

Accepted by: _____
Policyholder



PRESIDENT

This rider takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

EXCESS PROVISION

No benefit of this policy is payable for any expense incurred for Injury or Sickness which is paid or payable by: 1) other valid and collectible insurance; or, 2) under an automobile insurance policy.

This Excess Provision will not be applied to the first \$100 of medical expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier because of the Insured's failure to comply with policy provisions or requirements.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 365 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 endorsement when added to payment under the "Basic Medical Expense Benefit" (and under Supplemental Medical, if coverage is afforded under Supplemental Medical) shall not exceed the policy Maximum Benefit.

For Loss Of:

Life	\$10,000
Two or More Members	\$10,000
One Member	\$ 5,000

Loss shall mean with regard to hands and feet, 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.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

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.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

UnitedHealthcare Network Pharmacy Prescription Drug Benefits

Benefits are available for Prescription Drug Products at a Network Pharmacy as specified in the policy Schedule of Benefits subject to all terms of the policy and the provisions, definitions and exclusions specified in this endorsement.

Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable copayment and/or coinsurance; or
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable copayment and/or coinsurance; or
- The Prescription Drug Cost for that Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits as written by the Physician and the supply limits that are stated in the Schedule of Benefits. For a single copayment and/or coinsurance, the Insured may receive a Prescription Drug Product up to the stated supply limit.

When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the copayment and/or coinsurance that applies will reflect the number of days dispensed.

When a Prescription Drug Product is dispensed from a Mail Order Network Pharmacy, the Prescription Drug Product is subject to the supply limit stated in the Schedule of Benefits, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

Note: Some products are subject to additional supply limits based on criteria that the Company has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

The Insured may determine whether a Prescription Drug Product has been assigned a maximum quantity level for dispensing through the Internet at www.uhcsr.com or by calling *Customer Service* at 1-877-417-7345.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug may change, and therefore the copayment and/or coinsurance may change. The Insured will pay the copayment and/or coinsurance applicable for the tier to which the Prescription Drug is assigned.

Notification Requirements

Before certain Prescription Drug Products are dispensed at a Network Pharmacy, either the Insured's Physician, Insured's pharmacist or the Insured is required to notify the Company or our designee. The reason for notifying the Company is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Medical Expense.
- It is not an Experimental or Investigational or Unproven Service.

The Company or its designee will contact the Insured's Physician and the notification criteria will be reviewed with the Insured's Physician prior to approval or denial of the medication.

UnitedHealthcare Network Pharmacy Prescription Drug Benefits *(Continued)*

Prescription Drugs Products which require notification are:

Actiq, Anzemet, Avita-Penderm, Avodart, Copegus, Differin-Gladerma, Diflucan, Elidel, Emend, Genotropin, Humatrope, Increlex, Infergen, Intron-A, Iplex, Kytril, Lamisil, Lotronex, Norditropin, Nutropin, Nutropin AQ, Nutropin Depot, PEG-Intron, Pegasys, Proscar, Protopic, Protropin, Provigil, Raptiva, Regranex, Relenza, Retin-A, Retin-A Micro Ortho, Rebetol, Rebtron, Restasis, Revatio, Roferon, Sporanox, Saizen, Serostim, Tamiflu, Tazorac, Tracleer, Ventavis, Wellbutrin SR, Wellbutrin XL, Zelnorm, Zofran, Zorbive.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured may pay more for that Prescription Order or Refill. The Prescription Drugs requiring notification are subject to Company periodic review and modification. The Insured may determine whether a particular Prescription Drug requires notification through the Internet at www.uhscr.com or by calling *Customer Service* at 1-877-417-7345.

If the Company is not notified before the Prescription Drug Product is dispensed, the Insured can ask the Company to consider reimbursement after the Insured receives the Prescription Drug Product. The Insured will be required to pay for the Prescription Drug Product at the pharmacy.

When the Insured submits a claim on this basis, the Insured may pay more because they did not notify the Company before the Prescription Drug Product was dispensed. The amount the Insured is reimbursed will be based on the Prescription Drug Cost, less the required copayment and/or coinsurance, and any Deductible that applies.

Benefits may not be available for the Prescription Drug Product after the Company reviews the documentation provided and determines that the Prescription Drug Product is not a Covered Medical Expense or it is an Experimental or Investigational or Unproven Service.

Limitation on Selection of Pharmacies

If the Company determines that an Insured Person may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, the Insured Person's selection of Network Pharmacies may be limited. If this happens, the Company may require the Insured to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if the Insured uses the designated single Network Pharmacy. If the Insured does not make a selection within 31 days of the date the Company notifies the Insured, the Company will select a single Network Pharmacy for the Insured.

Coverage Policies and Guidelines

The Company's Prescription Drug List ("PDL") Management Committee is authorized to make tier placement changes on its behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others, therefore; a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

The Company may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to the Insured.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Insured Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Insured Person is a determination that is made by the Insured Person and the prescribing Physician.

UnitedHealthcare Network Pharmacy Prescription Drug Benefits (Continued)

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, the Insured may be required to pay more or less for that Prescription Drug Product. The Prescription Drug List will not be replaced mid-contract year. Please access www.uhcsr.com through the Internet or call *Customer Service* at t 1-877-417-7345 for the most up-to-date tier status.

Rebates and Other Payments

The Company may receive rebates for certain drugs included on the Prescription Drug List. The Company does not pass these rebates on to the Insured Person, nor are they applied to the Insured's Deductible or taken into account in determining the Insured's copayments and/or coinsurance.

The Company, and a number of its affiliated entities, conducts business with various pharmaceutical manufacturers separate and apart from this Prescription Drug Endorsement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug Benefit. The Company is not required to pass on to the Insured, and does not pass on to the Insured, such amounts.

Definitions

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

Chemically Equivalent means when Prescription Drug Products contain the same active ingredient.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

- 1) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- 2) Subject to review and approval by any institutional review board for the proposed use.
- 3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If the Insured has a life-threatening Injury or Sickness (one which is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- 1) Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- 2) Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

UnitedHealthcare Network Pharmacy Prescription Drug Benefits (Continued)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, determine that an Unproven Service meets the definition of a Covered Medical Expense for that Injury or Sickness. For this to take place, the Company must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "generic" by the manufacturer, pharmacy or Insured's Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

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 Cost means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call *Customer Service* at the telephone number on the Insured's ID card 1-800-767-0700.

Prescription Drug List Management Committee means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax

UnitedHealthcare Network Pharmacy Prescription Drug Benefits *(Continued)*

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-2.)
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury.

