2010-2011 SCHOOL YEAR

SOMA COLLEGE HEALTH INSURANCE PLAN RENEWAL BROCHURE

Dear SOMA Insured:

The attached billing shows the new health insurance premium effective 09/01/10. These new premiums will be applied to the premium payment option that you have selected at the time of your application. The options are:

1) Credit Card or Debit Card – Premium Charged Monthly
2) Checking Account Monthly

PLEASE NOTE: There will be 2 medical insurance plans available under the SOMA College Health Insurance Program. You may wish to elect the same medical insurance plan as last year or you may change to the other plan option. **The plan you select on September 1, 2010 cannot be changed until September 1, 2011.**

The schedule of benefits summary for the 2 medical plans are outlined on Pages 2 and 3; the Dental option is described on Page 4 and the Vision option is described on Page 5. The premiums for all the health plans and the dental and vision options are outlined on Page 9.

CHANGES TO THE 2010-2011 INSURANCE PROGRAM:

MEDICAL (Pages 2 & 3)

1. New Insurance Company – United States Fire Insurance Company

2. Premium increase of 6.5% for students with no change in benefits. No increase in premium for spouse and children.

DENTAL (Page 4) No change in premium or benefits

VISION (Page 5) No change in premium or benefits

PLEASE REFER TO THE 2010-2011 RENEWAL INSTRUCTIONS ON PAGE 9

The fastest and easiest way to make changes to your SOMA insurance plan is as follows:

1) **Go to the SOMA Health Insurance Website – www.somainsurance.com**

2) **Click "Administrative Forms"**

3) **To change Medical plans, add or delete Dental/Vision, coverage, use Form #8 (Enrollment Change Option Form), complete information, Click "Submit"**

A new I.D. Card and booklet will be sent to you.

Any Questions, Please Call Toll-Free
1-800-349-1039
8:00 A.M. – 4:30 P.M.
Or E-Mail – soma@mmicinsurance.com

For Administrative forms and claim information, go to the SOMA Insurance Website
www.somainsurance.com

SCHEDULE OF BENEFITS FOR 2010-2011 POLICY YEAR (Will Not Exceed Usual, Reasonable & Customary Charges)	Plan 1 - Co-Pay Plan	
SICKNESS AND INJURY BENEFITS (all benefit maximums are combined Preferred Providers/Out-of-Network unless otherwise noted)	**In-Network Preferred Provider**	**Out-of-Network Non-Preferred Provider**
Aggregate Lifetime Maximum.....	Unlimited	
Policy Year Aggregate Maximum Amount Per Sickness/Injury..	$100,000	
Deductible Per Insured Person (09/01/10 - 08/31/11).....	$250 Policy Year	$500 Policy Year
Coinsurance- Preferred Provider – 80% Out-of-Network- 60%.	80%*	60%*
Maximum Out-of-Pocket (Does Not Include Deductible)..... **After the Insured has incurred $9,750 out-of-pocket, this plan pays for 100% of Preferred Providers and 100% of Out-of-Network for covered medical expenses.**	$9,750	$9,750
Covered Charges - Inpatient Benefits 1. Room & Board /Hospital Misc.- $1,500 Aggregate max per day. 2. Intensive Care……..... 3. Routine Newborn Care (48 hours vaginal/96 hours caesarean)..... 4. Physiotherapy ……..... 5. Surgery..... 6. Asst. Surgeon (Secondary assistant surgeon fees are paid at 50% of Primary 7. Anethetist…….. 8. Registered Nurse's Services..... 9. Doctor's Visits..... 10. Pre-admission Testing; $1,500 Maximum..... 11. Psychotherapy.....	1. 80% of Preferred Allowance 2 Paid under R&B Hosp.Misc. 3. Paid as any other Sickness 4. Paid under R&B Hosp. Misc. 5. 80% of Preferred Allowance 6. 80% of Preferred Allowance 7. 25% of Surgery Allowance 8. 80% of Preferred Allowance 9. 80% of Preferred Allowance 10. 80% of Preferred Allowance 11. 80% of Preferred Allowance/ $25 per day/3 days max	(URC – Usual, Reasonable & Customary Charges) 1. 60% of URC 2. Paid under R&B Hosp Misc 3. Paid as any other Sickness 4. Paid under R&B Hosp Misc 5. 60% of URC 6. 60% of URC 7 . 25% of SurgeryAllowance 8. 60% of URC 9. 60% of URC 10. 60% of URC 11. 60% of URC $25 per day/3 days max
Covered Charges - Outpatient Benefits 1. Surgery..... 2. Day Surgery Miscellaneous - $1,500 max..... 3. Asst. Surgeon (Secondary assistant surgeon fees are paid at 50% of Primary)…….. 4. Anesthetist.....…….. 5. Doctor's Visits ……..... 6. Physiotherapy. - $50 max per visit/10 visit max..... 7. Outpatient Miscellaneous Benefits - $2,000 max..... 8. Medical Emergency..... 9. X-Rays & Laboratory..... 10. Radiation Therapy..... 11. Tests & Procedures..... 12. Injections. - $1,500 max..... 13. Chemotherapy..... 14. Psychotherapy - $1,500 max..... 15.Prescription Drugs (up to a $600 maximum per policy year), (after a $15 tier 1/$25 tier 2 Copay per prescription/31 day supply) After the per prescription deductible utilizing an Script Care, Ltd. Network pharmacy, the policy Deductible does not apply.	1. 80% of Preferred Allowance 2. 80% of Preferred Allowance 3. 80% of Preferred Allowance 4. 25% of Surgery Allowance 5. Paid under Outpatient Misc./ $25 copay per visit 6. 80% of Preferred Allowance 7. 80% of Preferred Allowance 8. 80% of Preferred Allowance 9. Paid under Outpatient Misc. 10. Paid under Outpatient Misc. 11. Paid under Outpatient Misc. 12. 80% of Preferred Allowance 13. Paid under Outpatient Misc. 14. 50% of Preferred Allowance 15. $15 copay tier 1/$25 tier 2 when utilizing the Script Care, Ltd. Network Pharmacy	1. 60% of URC 2. 60% of URC 3. 60% of URC 4. 25% of Surgery Allowance 5. Paid under Outpatient Misc./ $25 deductible per visit 6. 60% of URC 7. 60% of URC 8. 80% of URC 9. Paid under Outpatient Misc. 10. Paid under Outpatient Misc. 11. Paid under Outpatient Misc. 12. Usual & Customary Charges 13. Paid under Outpatient Misc. 14. 50% of Usual & Customary Charges 15. No Benefits - Prescriptions are only covered if filled at a Network Pharmacy
Covered Charges - Other Benefits 1. Ambulance - $200 max..... 2. Durable Medical Equipment.- $1,500 max..... 3. Dental (Benefits for injury to Sound - Natural Teeth Only)$500 max..... 4. Consultant…….. 5. Needle Stick……. 6. Alcoholism..... 7. Drug Abuse..... 8. Maternity(as mandated for maternity and post delivery care)..... 9. Elective Abortion..... 10. Complications of Pregnancy..... 11. Repatriation..... 12. Medical Evacuation..... 13. AD&D..... 14. Intercollegiate Sports..... 15. Home Health Care……..... 16. Cat Scan/MRI……. 17. Wellness Benefit - $150 max per policy year..... Wellness expense 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, a hemoglobin and urine test. For women, examination includes the office visit charge, pap smear, gonorrhea, Chlamydia test, hemocult for women over the age of 50, a hemoglobin and urine test. (Not subject to the Deductible).	1. 80% of URC 2. 80% of URC 3. 80% of URC 4. 80% of Preferred Allowance 5. Paid as any other Sickness 6. Paid as any other Sickness 7. Paid under Psychotherapy 8. Paid as any other Sickness 9. No Benefits 10. Paid as any other Sickness 11. Benefits provided by On Call International 12. Benefits provided by On Call International 13. $5,000 - $10,000 max 14. No Benefits 15. 80% of Preferred Allowance 16. Outpatient Miscellaneous 17. 80% of Preferred Allowance *Except as otherwise specified	1. 80% of URC 2. 80% of URC 3. 80% of URC 4. 60% of URC 5. Paid as any other Sickness 6. Paid as any other Sickness 7. Paid under Psychotherapy 8. Paid as any other Sickness 9. No Benefits 10. Paid as any other Sickness 11. Benefits provided by On Call International 12. Benefits provided by On Call International 13. $5,000 - $10,000 max 14. No Benefits 15. 60% of URC 16. Outpatient Miscellaneous 17. 60% of URC
Additional Benefits – mandate benefits vary by state. You may be eligible for additional benefits depending on your state or residence Please contact 1-877-246-6997 to see if you qualify for other benefits not shown on this schedule.		

SCHEDULE OF BENEFITS FOR 2010-2011 POLICY YEAR (Will Not Exceed Usual Reasonable & Customary Charges)	Plan 2 - High Deductible Health Plan (HDHP)	
SICKNESS AND INJURY BENEFITS	**Preferred Provider**	**Out-of-Network**
Aggregate Lifetime Maximum.....	Unlimited	
Policy Year Aggregate Maximum Amount Per Sickness/Injury.....	$100,000	
Deductible Per Insured Person (09/01/ 10 - 08/31/11).....	$2,000 Policy Year	$4,000 Policy Year
Coinsurance…….....	80%*	60%*
Maximum Out-of-Pocket (Does Not Include Deductible)..... **After the Insured has incurred $8,000 out-of-pocket, this plan pays for 100% of Preferred Providers and 100% of Out-of-Network for covered medical expenses.**	$8,000	$8,000
Covered Charges - Inpatient Benefits		(URC – Usual, Reasonable & Customary Charges)
1. Room & Board Hospital Miscellaneous.....	1. 80% of Preferred Allowance	1. 60% of URC
2. Intensive Care.....	2. Paid under R&B/Hosp Misc.	2. Paid under R&B/Hosp. Misc.
3. Routine Newborn Care (48 hours vaginal/96 hours caesarean)…….....	3. Paid as any other Sickness	3. Paid as any other Sickness
4. Physiotherapy…….....	4. Paid under R&B/HospMisc.	4. Paid under R&Bd/Hosp Misc.
5. Surgery.....	5. 80% of Preferred Allowance	5. 60% of URC
6. Asst. Surgeon (Secondary assistant surgeon fees are paid at 50% of Primary)……	6. 80% of Preferred Allowance	6. 60% of URC
7. Anesthetist.....	7. 25% of Surgery Allowance	7. 25% of Surgery Allowance
8. Registered Nurse.....	8. 80% of Preferred Allowance	8. 60% of (URC)
9. Doctor's Visits.....	9. 80% of Preferred Allowance	9. 60% of URC
10. Pre-admission Testing.....	10. 80% of Preferred Allowance	10 60% of URC
11. Psychotherapy.....	11. 80% of Preferred Allowance	11. 60% of URC
Covered Charges - Outpatient Benefits		
1. Surgery.....	1. 80% of Preferred Allowance	1. 60% of URC
2. Day Surgery Miscellaneous.....	2. 80% of Preferred Allowance	2. 60% of URC
3. Asst. Surgeon (Secondary assistant surgeon fees are paid at 50% of Primary).....	3. 80% of Preferred Allowance	3. 60% of URC
4. Anesthetist.....	4. 25% of Surgery Allowance	4. 25% of Surgery Allowance
5. Doctor's Visit …….....	5. 80% of Preferred Allowance	5. 60% of URC
6. Physiotherapy.....	6. 80% of Preferred Allowance	6. 60% of URC
7. Medical Emergency.....	7. 80% of Preferred Allowance	7. 80% of URC
8. X-Rays & Laboratory.....	8. 80% of Preferred Allowance	8. 60% of URC
9. Radiation Therapy.....	9. 80% of Preferred Allowance	9. 60% of URC
10.Tests & Procedures.....	10. 80% of Preferred Allowance	10. 60% of URC
11. Injections.....	11. 80% of Preferred Allowance	11. 60% of URC
12. Chemotherapy.....	12. 80% of Preferred Allowance	12. Usual & Customary Charges
13. Psychotherapy.....	13. 50% of Preferred Allowance	13. 50% of URC
14. Prescription Drugs (up to a $2,500 maximum per policy year).....	14. 80% of URC	14. 80% of URC
Covered Charges - Other Benefits		
1. Ambulance.....	1. 80% of URC	1. 80% of URC
2. Durable Medical Equipment.....	2. 80% of URC	2. 80% of URC
3. Dental (Benefits for injury to Sound - Natural Teeth).....	3. 80% of URC	3. 80% of URC
4.Consultant……..	4. 80% of Preferred Allowance	4. 80% of URC
5.Needle Stick……..	5. Paid as any other Sickness	5. Paid as any other Sickness
6.Alcoholism.....	6. Paid as any other Sickness	6. Paid as any other Sickness
7. Drug Abuse.....	7. Paid under Psychotherapy	7. Paid under Psychotherapy
8. Maternity (as mandated for maternity and post delivery care).....	8. Paid as any Other Sickness	8. Paid as any Other Sickness
9. Elective Abortion.....	9. No Benefits	9. No Benefits
10. Complications of Pregnancy.....	10. Paid as any Other Sickness	10. Paid as any Other Sickness
11. Repatriation.....	11. Benefits provided by On Call International	11. Benefits provided by On Call International
12. Medical Evacuation.....	12. Benefits provided by On Call International	12. Benefits Provided by On Call International
13. AD&D.....	13. $5,000-$10,000 max	13. $5,000-$10,00 max
14 Intercollegiate Sports.....	14 No Benefits	14. No Benefits
15. Home Health Care….....	15. 80% of Preferred Allowance	15. 60% of URC
16. CAT Scan/MRI……	16. 80% of Preferred Allowance	16. 60% of URC
17. Wellness Benefit.....	17. 80% of Preferred Allowance	17. 60% of URC
Wellness expense 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, a hemoglobin and urine test. For women, examination includes the office visit charge, pap smear, gonorrhea, Chlamydia test, hemocult for women over the age of 50, a hemoglobin and urine test.		
Additional Benefits – mandate benefits vary by state. You may be eligible for additional benefits depending on your state or residence Please contact 1-877-246-6997 to see if you qualify for other benefits not shown on this schedule.	*Except as otherwise specified	

PRESCRIPTION DRUG CARD

Plan 1 - Co-Pay Plan Only

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a Script Care, Ltd. Network Pharmacy. Benefits are subject to supply limits (up to 31 days) and copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are a few Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable copayments. Your copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access http://www.scriptcare.com or call 800-880-9988 or the customer service number on your ID card for the most up-to-date tier status.

$15 copay per prescription order or refill for a **Tier 1** Prescription Drug
$25 copay per prescription order or refill for a **Tier 2** Prescription Drug

Your maximum allowed benefit is $600 per policy year.

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

If you do not present the card, you will need to pay the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please call Summit America Insurance Services, LC at 877-246-6997 or the customer service number on your ID card.

MEDICAL PLAN ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

Loss of Life/Dismemberment (two or more members)..... $10,000
Loss of One Member *.....$5,000
* Member means hand, arm, foot, leg or eye

MEDICAL EXCLUSIONS

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

1. Learning Disabilities;

2. Biofeedback;

3. Circumcision, except if medically necessary due to Injury, illness, disease, or functional congenital disorder;

4. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;

5. Dental treatment, except for accidental Injury to Sound, Natural Teeth;

6. Elective Surgery or Elective Treatment;

7. Elective abortion;

8. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision

4.

correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
hearing, apart from the disease process.

9. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

10. Hirsutism;

11. Immunizations, preventive medicines or vaccines, except where required for treatment of a covered Injury;

12. Injury caused by, or resulting from the use of alcohol, intoxicants, hallucinogenics, illegal drugs, or any drugs or medicines that are not taken in the recommended dosage or for the purpose prescribed by the Insured Person's Physician; intoxication is defined and determined by the laws of the state where the loss or cause of the loss was incurred;

13. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.

MEDICAL EXCLUSIONS CONTINUED

14. Injury sustained while (a) participating in any interscholastic, club, intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;

15. Organ transplants; only those considered experimental are excluded.

16. *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 provides documentation of continuous coverage under a prior health insurance policy which provided benefits similar to this policy;

17. 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 Policy;

(b) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;

(c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;

(d) Products used for cosmetic purposes;

(e) Drugs used to treat or cure baldness, anabolic steroids used for body building;

(f) Anorectics - drugs used for the purpose of weight control;

(g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;

(h) Growth hormones, except when a Medical Necessity; or

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

18. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;

19. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;

20. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the Policy;

21. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

22. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;

23. Sleep disorders;

24. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

25. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy;

26. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;

27. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and

28. Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia, except as specifically provided in the policy. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

* the time the Insured was covered under previous creditable coverage will be credited if previous coverage was continuous to a date not more than 63 days before the effective date of this coverage.

Exclusions and Limitations may vary by state

This brochure is not a contract of insurance. Terms and conditions of coverage and benefits are set forth in a Master Certificate issued to Student Osteopathic Medical Association. These plans are underwritten by United States Fire Insurance Company (Medical), United Concordia Life And Health Insurance Company (Dental), and VSP (Vision).

This plan issued to SOMA is a one year non-renewable term policy. This policy is excess to any other insurance policy you may have. No benefit of this policy is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance. This excess provision will not be applied to the first $100 of medical expenses incurred. Benefits are provided as mandated by the State of Illinois.
Benefits may vary by state.

OPTIONAL DENTAL PROGRAM

Dental benefits are provided through a stand-alone group dental insurance policy.

	In-Network	*Out-of-Network
• Contract Year Maximum per Covered Person • Contract Year Deductible per Covered Person/Family – Class I exempt	$1,500 $25/$75	$1,500 $25/$75
Class I Dental Plan Payment (no waiting period or deductible) • Exams • All X-rays • Cleanings • Fluoride Treatments • Sealants • Palliative Treatment	100%	100%
Class II Dental Plan Payment (no waiting period, deductible applies) • Space Maintainers • Basic Restorative • Non-surgical Periodontics • Repairs of Crowns, Inlays, Onlays, Bridges and Dentures • Simple Extractions	90%	90%
Class III Dental Plan Payment (six-month waiting period, deductible applies) • Endodontics • Surgical Periodontics • Complex Oral Surgery • General Anesthesia • Inlays, Onlays, Crowns • Prosthetics	50%	50%
Orthodontics	Not Covered	Not Covered

* Plan payment percentages are based on the insurance company's Maximum Allowable charge. Network dentists accept their contracted Maximum Allowable Charge as payment in full for covered services

DENTAL EXCLUSIONS

No coverage will be provided for services, supplies or charges:

1. Not specifically listed as a Covered Service on the Schedule of Benefits and those listed as not covered on the Schedule of Benefits.

2. Which are necessary due to patient neglect, lack of cooperation with the treating dentist or failure to comply with a professionally prescribed Treatment Plan. This exclusion does not apply to Group Policies and Certificates issued and delivered in California.

3. Stated prior to the Member's Effective Date or after the Termination Date of coverage with the Company, including, but not limited to multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays and dentures.

4. Services or supplies that are not deemed generally accepted standards of dental treatment.

5. For hospitalization costs.

6. That are the responsibility of Worker's Compensation or employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.
For Group Policies and Certificates issued and delivered in Georgia, Missouri, and Virginia, only services that are the responsibility of Workers Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Policies and Certificates issued and delivered in Texas, only services that are the responsibility the employer's liability insurance, or for treatment of any automobile related injury shall be excluded from this Plan.

7. For prescription or non-prescription drugs, vitamins, or dietary supplements.

8. Administration of nitrous oxide, general anesthesia and i.v. sedation, unless specifically indicated on the Schedule of Benefits.

9. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

This exclusion does not apply to Group Policies and Certificates issued and delivered in Pennsylvania for Cosmetic services required as the result of an accidental injury. This exclusion does not apply to Group Policies issued and delivered in New Jersey for Cosmetic services for newlyborn children of Members as defined in the definition of Dependent.

10. Elective procedures including but not limited to the prophylactic extraction of third molars.

11. For the following which are not included as orthodontic benefits - retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance.

12. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment.

For Group Policies and Certificates issued and delivered in Arizona, Kentucky, and Pennsylvania this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including adoptive children, regardless of age.

For Group Policies issued and delivered in Colorado, this exclusion shall not apply to orthodontic or dental services for a newly born Dependent with cleft lip or cleft palate and shall be covered as listed on the Schedule of benefits.

For Group Policies and Certificates issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

DENTAL EXCLUSIONS CONTINUED

13. For dental implants including placement and restoration of implants unless specifically covered under a rider to the Certificate. This exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

14. For oral or maxillofacial services including but not limited to associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth. This exclusion shall not apply to Group Policies issued and delivered in Georgia when such services are medically necessary.

15. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under a Rider to the Certificate. These jaw point problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint. For Group Policies and Certificates issued in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for Treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.

16. For treatment of fractures and dislocations of the jaw. This exclusion does not apply to Group Policies and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.

17. For treatment of malignancies or neoplasms.

18. Services and/or appliances that alter the vertical dimension, including but not limited to full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method. This exclusion does not apply to Group Policies and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.

19. Replacement of lost, stolen or damaged prosthetic or.orthodontic appliances

20. For broken appointments.

21. Arising from any intentionally self-inflicted injury or contusion when the injury is a consequence of the Member's commission of or attempt to commit a felony or engagement in an illegal occupation or of the Member's being intoxicated or under the influence of illicit narcotics. This exclusion does not apply to Group Policies and Certificates issued and delivered in Maryland.

22. For house or hospital calls for dental services.

23. Replacement of existing crowns, onlays, bridges and dentures that are or can be made serviceable.

24. Preventive restorations in the absence of dental disease.

25. Periodontal splinting of teeth by any method.

26. For duplicate dentures, prosthetic devices or any other duplicate device.

27. For services determined to be furnished as a result of a referral to an entity in which the referring dentist, or the dentist's immediate family; (a) owns a beneficial interest; or (b) has a compensation arrangement. The dentist's immediate family includes the spouse, child, child's souse, parent, spouse's parent, sibling or sibling's spouse of the dentist or that dentist in combination.

28. For which in the absence of insurance the Member would incur no charge.

29. For plaque control programs, oral hygiene, and dietary instructions.

30. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the guard or in the armed forces of any country or international authority. This exclusion does not apply to Group Policies and Certificates issued and delivered in Oklahoma.

31. For training and/or appliance to correct or control harmful habits, but not limited to muscle training therapy (myofunctional therapy).

32. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.

33. Which are not Dentally Necessary as determined by the Company. This exclusion does not apply to Group Policies and Certificates in California and Maryland.

DENTAL LIMITATIONS

The following services will be subject to limitations as set forth below:

1. Full mouth x-rays - one every five years.
2. One set(s) of bitewing x-rays per six months through age thirteen, and one set(s) of bitewing x-rays per twelve months for age fourteen and older.
3. Periodic oral evaluation - one per six months.
4. Limited oral evaluation (problem focused) - limited to one per dentist per twelve months.
5. Prophylaxis - one per six months.
6. Fluoride treatment - one per six months through age eighteen.
7. Space maintainers - only eligible for Members through age eighteen when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molar that have not, or will not develop.
8. Prefabricated stainless steel crowns - one per tooth per lifetime for age fourteen years and younger.
9. Crown lengthening - one per tooth per lifetime.
10. Periodontal maintenance following active periodontal therapy - two per twelve months in addition to routine prophylaxis.
11. Periodontal scaling and root planing - per two year period per area of the mouth.
12. Placement or replacement of single crowns, inlays, onlays, single and abutment buildups and post and cores, bridges, full and partial dentures - one within five years of their placement.
13. Denture relining, rebasing or adjustments - are included in the denture charges if provided within six months of insertion by the same dentist.
14. Subsequent denture relining or rebasing - limited to one every three year(s) thereafter.
15. Surgical periodontal procedures - one per two year period per area of the mouth.
16. Sealants - one per tooth per three year(s) through age fifteen on permanent first and second molars.
17. Pulpal therapy - through age five on primary anterior teeth and through age eleven on primary posterior molars.
18. Root canal treatment and retreatment - one per tooth per lifetime.
19. Recementations by the same dentist who initially inserted the crown or bridge during the first twelve months are included in the crown or bridge benefit, then one per twelve months thereafter; one per twelve months for other than the dentist who initially inserted the crown or bridge.
20. Replacement restorations - limited to one per twelve months.
21. Contiguous surface posterior restorations not involving the occlusal surface will be payable as one surface restoration.
22. Posts are only covered as part of a post buildup.
23. An Alternate Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed for the ABP.
24. Payment for orthodontic services shall cease at the end of the Month after termination by the Company.

OPTIONAL VISION PROGRAM

Vision Benefits are provided through a stand-aloneVision program

Benefit	Frequency (based on service year)	Copayment	Coverage from a Network Doctor	Out-of-Network Reimbursement
Eye Care Wellness - Regular exams are essential for protecting your visual wellness				
Exam	12 Months	$20	Covered in full	Up to $25 Allowance
Prescription Eyewear - You may choose between glasses or contacts. Remember if you choose contacts, you will not be eligible to receive glasses (lenses and frame) in the same service period.				
Lenses	12 Months	$20 (applied to lenses & frame)	Single vision, lined bifocal lenses, lined trifocal lenses and tints are covered in full	Single vision up to $30 allowance Lined bifocal up to $35 allowance Lined trifocal up to $45 allowance Tints up to $5 allowance
Frame	12 Months		Covered up to $140 allowance	Up to $45 allowance
Contact Lenses	12 Months	None	Covered up to $140 allowance	Up to $105 allowance

Your allowance applies to the cost of your contact lens exam and your contact lenses. You will receive a 15 percent savings off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Value Added Discounts
Laser VisionCare - The Vision Coverage Company has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers.
Contact Lenses - Valuable savings are available on annual supplies of certain brands of contacts. You can receive these member preferred prices, even if you use your coverage for glasses.
Prescription Glasses - Receive 20 percent savings when you purchase non- covered pairs of prescription g lasses, including prescription sunglasses from the same in- network doctor within 12 months of your last eye exam.

1. Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at member preferred pricing. Ask your doctor for details.
2. If you choose a frame valued at more than your allowance, you'll save 30% on your out-of-pocket costs for frames.

VISION LIMITATIONS & EXCLUSIONS

As a plan designed to meet the typical visual needs of its members, we limit or do not cover some materials and certain elective options chosen for cosmetic purposes. We also do not cover medical or surgical eye care services, with the exception of discounts available for laser vision correction services. The following lists materials and services with either limited or no coverage under the Standard Plan.

Cosmetic Options
- Blended lenses*
- Contact lenses (except as noted elsewhere)
- Scratch resistant coating *
- Anti-reflective coating *
- UV protected lenses
- Oversized lenses (over 60 mm)*
- Progressive multifocal *
- Photochormic or tinted lenses other than Pink 1 or 2
- Other coated or laminated lenses *
- Certain limitations on low vision care
- Optional cosmetic processes

Exclusions (services and materials not covered)
- Orthoptics or vision training and any associated supplemental testing.
- Non-prescription lenses
- Two pairs of glasses instead of bifocals
- Complete pairs of glasses furnished under this program that are lost or broken (except at the normal intervals when services are otherwise available)
- Medical or surgical treatment of the eyes
- Experimental vision services, treatments and materials

* Cosmetic Options: Lens features not covered under the plan and chosen for cosmetic reasons, such as blended/ progressive lenses, special lens tints or coatings are price controlled by VSP. These cost controlled prices can save our members an average of 20% off doctor's usual and customary fees.

2010-2011 PREMIUM RATES

MONTHLY PREMIUM

	Medical Plan		Vision Plan	Dental Plan
	Plan 1 Co-Pay Plan	Plan 2 High Deductible (HDHP)		
Student Only Under Age 30 Age 30 & Over	$175 $208	$104 $123	$16	$38
Spouse Only Under Age 30 Age 30 & Over (Based on Student's Age)	$354 $426	$198 $237	$9.30	$32
Child(ren) Under Age 30 Age 30 & Over	$262 $262	$159 $159	$16.50	$43

2010-2011 RENEWAL INSTRUCTIONS

1) If you wish to renew your current medical insurance plans that you applied for last year, no action is necessary. The new monthly premium on the billing advice will be charged to your Credit or Debit Card, or debited from your checking account effective September 1, 2010 based on your current payment option.

2) If you wish to change to a different insurance plan, complete the **Enrollment Change Option Form** (Page 11) or **complete and submit this information using the "Enrollment Change Option Form" on the SOMA Insurance website – www.somainsurance.com; Click "Administrative Forms", use Form #8 (Enrollment Change Option Form).** The premiums for your new plan selection will be charged to your Credit or Debit Card, or debited to your checking account on September 1, 2010.

3) If you wish to have premiums charged monthly to a credit card (MasterCard or VISA) instead of having premiums withdrawn from your checking account, complete the Credit Card Authorization of the **Monthly Automatic Pay Plan Form** (Page 12) send send it along with a check for the first Month's premium, or **complete the "Monthly Automatic Pay Plan Form" on the SOMA Insurance website – www.somainsurance.com.** This payment will be applied to your Credit or Debit Card or debited to your checking account on September 1, 2010.

Please Note:

1) If you submit changes using the SOMA Insurance website, www.somainsurance.com, the Enrollment change Form on Page 11 does need to be mailed.

2) If you do not wish to use the SOMA insurance website, send forms on Page 11 and/or 12 to SOMA Insurance Plan, P.O. Box 95, Orland Park, IL 60462

Questions? E-Mail soma@mmicinsurance.com or
Call Toll-Free – 1-800-349-1039

MOST FREQUENTLY ASKED QUESTIONS ABOUT THE SOMA COLLEGE HEATH INSURANCE PLAN

1) Can I switch plans during the school year?
No - the plan you enroll in cannot be changed until September 1, 2011.

2) Is there a pre-existing condition limitation under the SOMA program?
Yes. Pre-existing Conditions are not covered for the first 12 months following an Insured Person's effective Date of coverage. However, the time an Insured Person was covered under previous creditable coverage will be credited if previous coverage was continuous to a date not more than 63 days before the Effective Date of this coverage.
A Pre -existing Condition means: 1) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 months immediately prior to the Insured's effective date under the policy or 2) any condition which originates, is diagnosed treated or recommended for treatment within the 12 months immediately prior to the Insured's effective date under the Policy. The pre-existing condition limitation does not apply to the dental/vision option.

3) How do I get reimbursed for expenses?

Medical - You must complete a claim form and send it along with your medical bills to Summit America Insurance Services, LC, 7400 College Blvd., Suite 100 Overland Park, KS 66210. It is your responsibility to file a claim and provide written notice of your claim within 90 days from the date of any treatment.

Dental - Participating providers file all claim forms and accept reimbursement from United Concordia as payment in full. If an out-of-network provider is selected, a detailed bill provided by the dentist must be submitted to United Concordia for reimbursement. (United Concordia Life and Health Insurance Company, 4401 Deer Path Road, Harrisburg, PA 17110).

Vision - Participating providers file all claim forms and accept reimbursement from VSP as payment in full. If an out-of-network provider is selected, an out-of-network reimbursement form must be completed and submitted to VSP. (VSP, P.O. Box 997105, Sacramento, CA 95899 -7105).

4) Do I need to inform the insurance company in advance of any hospitalization?
No pre-certification is required but pre-admission notification is recommended prior to planned admissions or emergency admissions.

5) When will my coverage become effective?
The effective date will be the 1st of the month if the enrollment form is received by the Administrator between the 1st and 15th of any month. If the postmark date of the enrollment form is between the 16th and 31st of any month, your effective date will be the first of the following month.

Endorsed By:
Student Osteopathic Medical Association
142 East Ontario Street
Chicago, IL 60611
1-800-621-1773, x 8193

Arranged By:
Mass Marketing Insurance Consultants, Inc.
14616 John Humphrey Drive
Orland Park, IL 60462
1-800-349-1039

Claims/EligibilityAdministration:
Summit America Insurance Services, LC
7400 College Blvd, Suite 100
Overland Park, KS 66210
1-877-246-6997

Underwritten By:

Medical
United States Fire Insurance Company
by Fairmont Specialty, a part of Crum & Forster
5 Christopher Way
Eatontown, NJ 07724

Dental
United Concordia Life And Health Insurance Company
4401 Deer Path Road
Harrisburg, PA 17110

Vision
VSP
3333 Quality Drive
Rancho Cordova, CA 95670

2009-2010 ENROLLMENT CHANGE OPTION FORM

The information on this form can be submitted using the SOMA Insurance website – www.somainsurance.com. (Click Administrative Forms – Form # 8).

Complete this form only if you wish to mail your changes
(Change in plan(s) must be made by September 15, 2010)

Name:_____
ID. #_____

The requested change to my current SOMA College Health Insurance coverage plan election effective September 1, 2010 is as follows:

PLEASE CHANGE MY CURRENT COVERAGE:

MEDICAL INSURANCE

FROM	TO
☐ Plan 1	☐ Plan 1
☐ Plan 2	☐ Plan 2

OPTIONAL PLANS

VISION INSURANCE OPTION	DENTAL INSURANCE OPTION
☐ Do not add the Vision option to my Health Plan ☐ Continue the Vision option with my new Health Plan ☐ Add the Vision option to my new Health Plan ☐ Delete the Vision option from my new Health Plan	☐ Do not add the Dental option to my Health Plan ☐ Continue the Dental option with my new Health Plan ☐ Add the Dental option to my new Health Plan ☐ Delete the Dental option from my new Health Plan

This coverage will be effective September 1, 2010

I understand and agree that the change to the new Health Plan I have chosen will not be in effect unless this Enrollment Change Option Form and premium is received by Mass Marketing Insurance Consultants, Inc.

All other terms of the SOMA Health Insurance coverage will remain in effect. Coverage will only be modified to the extent expressly stated in this Enrollment Change Option Form.

Dated at:_____ By: _____

Any Questions, Call Toll Free

1-800-349-1039

8:00 A.M. - 4:30 P.M. Central Standard Time

For administrative forms and claim information, go to the SOMA Health Insurance Website

www.somainsurance.com

Note: All medical insurance plans are non-renewable one year term policies. You will be mailed a new policy upon enrollment.

MONTHLY AUTOMATIC PAY PLAN FORM

To Be Completed by Members Who Wish to Pay Insurance Premium Monthly

SELECT METHOD OF PAYMENT

☐ **Monthly Credit Card** ☐ **Monthly Debit Card** ☐ **Monthly Check-O-Matic**

Credit Card Authorization

☐ VISA ☐ MasterCard

I authorize Mass Marketing Insurance Consultants, Inc. (MMIC) to bill my credit card account for the total amount due. This authority is to remain effective until I provide MMIC with written notification of cancellation. I understand that two weeks notice will be needed to implement any action.

Applicant Name:_____

Acct. #					-					-					-					Exp. Date						

Year Month Date

Signature:_____ **Date:**_____

Check-O-Matic Authorization

Applicant Name:_____

Name of Depositor:_____
Print exact name as it appears on financial institution records

Address:_____
(Street) (City) (State) (Zip Code)

Routing No.										**Account No.**												

I (we) hereby authorize Mass Marketing Insurance Consultants, Inc. to initiate debit entries to my (our) checking account (or savings account) and the Financial Institution named below to debit the same to such account. Mass Marketing Insurance Consultants, Inc. will not be held responsible for a policy lapse or cancellation due to non-payment if the withdrawal is presented and not honored for any reason and the amount is not paid.

Financial Institution Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

This authority is to remain effective until I (we) provide Mass Marketing Insurance Consultants, Inc. with written notification of cancellation two weeks before the date of termination.
Note: If the direct payment by check transactions is returned for non-sufficient funds, a $25 non-refundable service fee will be applied when allowed by state.

Signature:_____ **Date:**_____