

GRADUATE STUDENT

COLLEGE HEALTH INSURANCE PROGRAM 2009-2010 SCHOOL YEAR

Choice of 2 Medical Plans Now Available To

New Jersey School of Osteopathic Medicine

- 1) Osteopathic Medical Students**
- 2) Associate Members**

HIGHLIGHTS

- ▲ Acceptance is Guaranteed**
- ▲ Medical Prescription Drug Card (Plan 1)
\$15 Tier 1/\$25 Tier 2 Copay**
- ▲ Doctor Office Visit Copay - \$25 (Plan 1)**
- ▲ Vision Plan Option**
- ▲ Dental Plan Option**

GRADUATE STUDENT COLLEGE HEALTH INSURANCE PROGRAM

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Any Questions On

The Graduate Student College Health Plan

Call Toll-Free

800-349-1039

8:00 A.M. - 5:00 P.M.

Central Standard Time



IMPORTANT INFORMATION ON THE GRADUATE STUDENT COLLEGE HEALTH INSURANCE PLANS

The Health Insurance Plan now offers two medical insurance alternatives, in addition to a dental and vision insurance option.

Significant and substantial changes have been implemented since inception of the plan, which now makes it one of the best insurance programs available to medical school professionals.

PLEASE NOTE: After the deductible, the accident and sickness (medical) insurance plan has an 80% co-insurance feature, however, we would like to call your attention to the maximum limits per policy year on the following charges for Plans 1, and 2, also outlined on pages 4 and 5 in this brochure. **The deductible for Plan 1 does not apply for Prescription Drugs which has a \$15 Tier 1/\$25 Tier 2 co-pay (subject to a \$600 maximum per policy year); 2) Wellness Benefits; 3) Doctor Office Visit. Under Plan 2 (High Deductible) - a \$2,000 deductible must be satisfied before the plan pays any covered charges.**

	Plan 1	Plan 2
In Patient Covered Charges 1. Hospital Expense 2. Doctor's Fee for subsequent Procedure Performed at same operative session 3. Pre-Admission Testing	80% \$1,500/maximum per day 50% of primary 80%/\$1,500 max	80% 50% of Primary 80%
Out-Patient Benefit Max 1. Day Surgery 2. Out Patient Miscellaneous 3. Injections 4. Prescription Drugs (Per Policy Year) 5. Durable Medical Equipment 6. Psychotherapy *	80% \$1,500 max \$2,000 max \$1,500 max \$600 max \$1,500 50% /\$1,500 max	80% 80% 80% 80% /\$2,500 max 80% 50%

*Biologically Based Mental Illness paid as any other Sickness

Benefits will be coordinated with any other group medical, surgical, or hospital plan. This plan is a one year non-renewable term policy. Benefits are provided as mandated by the State of New Jersey.

HOW TO APPLY

- 1) Turn to Page 12 for How To Apply Instructions (Rates are outlined on Page 13).
- 2) The enrollment form on Page 14 must be completed and signed.
- 3) Members who wish to pay monthly must complete the Monthly Automatic Pay Plan form on Page 15.

We urge you to carefully review the insurance plans described in this booklet on Pages 4-6. If you have any questions or need any assistance, please call our experienced insurance administrator toll-free at 1-800-349-1039.

**SCHEDULE OF BENEFITS SUMMARY FOR 2009-2010
POLICY YEAR (Will Not Exceed Usual & Customary Charges)**

Co-Pay Plan 1 (2009-200463-1)

SICKNESS AND INJURY BENEFITS	
Aggregate Lifetime Maximum.....	No Lifetime Maximum
Policy Year Aggregate Maximum Amount Per Sickness/Injury.....	\$100,000
Deductible Per Insured Person (09/01/09 - 08/31/10).....	\$250 Policy Year
Coinsurance - 80%	80%*
Maximum Out-of-Pocket (Does Not Include Deductible)..... After the Insured has incurred \$9,750 out-of-pocket, this plan pays 100% Of Preferred Providers for additional covered medical expenses	\$9,750
Covered Charges - Inpatient Benefits 1. Room & Board Hospital Miscellaneous \$1,500 Aggregate max per day..... 2. Intensive Care..... 3. Routine Newborn Care/Post Partum Care (48/96 hospital confinement expense maximum)..... 4. Physiotherapy..... 5. Surgery..... 6. Assistant Surgeon (includes benefits for secondary Assistant Surgeon Fees at 50% of primary Assistant Surgeon Fee Allowance)..... 7. Anesthetist..... 8. Registered Nurse's Services..... 9. Physician's Visits..... 10. Pre-admission Testing. - \$1,500 Max..... 11. Psychotherapy..... 12. Biologically Based Mental Illness (as mandated by the State of New Jersey).....	1. Usual & Customary Charges 2. Paid under R&B Hosp. Misc. 3. Paid as any other sickness 4. Paid under R&B Hosp. Misc. 5. Usual & Customary Charges 6. Usual & Customary Charges 7. 25% of Surgery Allowance 8. Usual & Customary Charges 9. Usual & Customary Charges 10. Usual & Customary Charges 11. Usual & Customary Charges/ \$25 per day/3 days max 12. Paid as any other Sickness
Covered Charges - Outpatient Benefits 1. Surgery..... 2. Day Surgery Miscellaneous - \$1,500 max..... 3. Assistant Surgeon (includes benefits for secondary Assistant Surgeon Fees at 50% of primary Assistant Surgeon Fee Allowance)..... 4. Anesthetist..... 5. Physician's Visits	1. Usual & Customary Charges 2. Usual & Customary Charges 3. Usual & Customary Charges 4. 25% of Surgery Allowance 5. Paid under Outpatient Misc./ \$25 deductible per visit 6. Usual & Customary Charges 7. Usual & Customary Charges 8. Usual & Customary Charges 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. Paid as any other Sickness 16. \$15 Copay – Tier 1/\$25 Copay – Tier 2, when utilizing a UnitedHealthcare 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/Face Splash as a result of course work..... 6. Cat Scan/MRI..... 7. Alcoholism (as mandated by the State of New Jersey)..... 8. Drug Abuse..... 9. Maternity..... 10. Elective Abortion..... 11. Complications of Pregnancy..... 12. Repatriation..... 13. Medical Evacuation..... 14. AD&D..... 15. Intercollegiate Sports..... 16. Home Health Care (as mandated by the State of New Jersey)..... 17. Wellness Examinations and Counseling..... Not subject to the deductible, subject to maximums set forth by the State of New Jersey	1. Usual & Customary Charges 2. Usual & Customary Charges 3. Usual & Customary Charges 4. Usual & Customary Charges 5. Paid as any other Injury or Sickness 6. Paid under Outpatient Misc. 7. Paid as any other Sickness 8. Paid under Psychotherapy 9. Paid as any other Sickness 10. No Benefits 11. Paid as any other Sickness 12. Benefits provided by Scholastic Emergency Services, Inc. 13. Benefits provided by Scholastic Emergency Services, Inc. 14. \$5,000-\$10,000 max 15. No Benefits 16. Paid as any other Sickness 17. Paid as any other Sickness

*Except as otherwise specified

SCHEDULE OF BENEFITS FOR 2009-2010 POLICY YEAR (Will Not Exceed Usual & Customary Charges)

Plan 2 - High Deductible Health Plan (HDHP) (2009-200463-5)

SICKNESS AND INJURY BENEFITS	
Aggregate Lifetime Maximum.....	No Lifetime Maximum
Policy Year Aggregate Maximum Amount Per Sickness/Injury.....	\$100,000
Deductible Per Insured Person (09/01/09 - 08/31/10).....	\$2,000 Policy Year
Coinsurance - 80%	80%*
Maximum Out-of-Pocket (Does Not Include Deductible)..... After the Insured has incurred \$8,000 out-of-pocket, this plan pays for 100% for additional covered medical expenses.	\$8,000
Covered Charges - Inpatient Benefits 1. Room & Board Hospital Miscellaneous..... 2. Intensive Care..... 3. Routine Newborn Care/Post Partum Care - (4 days hospital confinement expense max).. 4. Physiotherapy..... 5. Surgery..... 6. Assistant Surgeon (includes benefits for secondary Assistant Surgeon Fees at 50% of primary Assistant Surgeon Fee allowance)..... 7. Anesthetist..... 8. Registered Nurse..... 9. Physician's Visits..... 10. Pre-admission Testing..... 11. Psychotherapy..... 12. Biologically Based Mental Illness (as mandated by the State of New Jersey).....	1. Usual & Customary Charges 2. Paid under R&B/Hosp. Misc. 3. Paid as any other Sickness 4. Paid under Room&Board/Hosp Misc. 5. Usual & Customary Charges 6. Usual & Customary Charges 7. 25% of Surgery Allowance 8. Usual & Customary Charges 9. Usual & Customary Charges 10. Usual & Customary Charges 11. Usual & Customary Charges 12. Paid as any other Sickness
Covered Charges - Outpatient Benefits 1. Surgery..... 2. Day Surgery Miscellaneous..... 3. Assistant Surgeon (includes benefits for secondary Assistant Surgeon Fees at 50% of primary Assistant Surgeon Fee Allowance)..... 4. Anesthetist..... 5. Physician's Visit (30 visits maximum)..... 6. Physiotherapy..... 7. Medical Emergency..... 8. X-rays & Laboratory..... 9. Radiation Therapy..... 10. Tests & Procedures..... 11. Injections..... 12. Chemotherapy..... 13. Psychotherapy..... 14. Prescription Drugs (up to a \$2,500 maximum per policy year)..... 15. Biologically Based Mental Illness (as mandated by the State of New Jersey).....	1. Usual & Customary Charges 2. Usual & Customary Charges 3. Usual & Customary Charges 4. 25% of Surgery Allowance 5. Usual & Customary Charges/30 visits max 6. Usual & Customary Charges 7. Usual & Customary Charges 8. Usual & Customary Charges 9. Usual & Customary Charges 10. Usual & Customary Charges 11. Usual & Customary Charges 12. Usual & Customary Charges 13. 50% of Usual & Customary Charges 14. Usual & Customary Charges 15. Paid as any other Sickness
Covered Charges - Other Benefits 1. Ambulance..... 2. Durable Medical Equipment..... 3. Dental (Benefits for injury to Sound Natural Teeth only)..... 4. Consultant..... 5. Needle Stick/Face Splash as a result of course work..... 6. Alcoholism (as mandated by the State of New Jersey)..... 7. Drug Abuse..... 8. Maternity..... 9. Elective Abortion..... 10. Complications of Pregnancy..... 11. Repatriation..... 12. Medical Evacuation..... 13. AD&D..... 14. Intercollegiate Sports..... 15. Home Health Care (as mandated by the State of New Jersey)..... 16. Wellness Examinations and Counseling..... Subject to maximums set forth by the State of New Jersey	1. Usual & Customary Charges 2. Usual & Customary Charges 3. Usual & Customary Charges 4. Usual & Customary Charges 5. Paid as any other Injury or 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 Scholastic Emergency Services, inc. 12. Benefits provided by Scholastic Emergency Services, Inc. 13. \$5,000-\$10,000 14. No Benefits 15. Paid as any other Sickness 16. Paid as any other Sickness *Except as otherwise specified

MEDICAL PLAN 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 UnitedHealthcare Network Pharmacy. Benefits are subject to supply limits 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 www.uhcsr.com or call 877-417-7345 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
- Mail order prescription drugs are available at 2.5 times the retail copy up to a 90 day supply.
- 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 visit www.uhcsr.com and log in to your online account or call 877-417-7345 or the customer service number on your ID card.

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.

MEDICAL PLAN 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

OPTIONAL DENTAL PROGRAM

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

	In-Network	*Out-of-Network
<ul style="list-style-type: none"> • 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

OPTIONAL VISION PROGRAM

Vision Benefits are provided through a stand-alone Vision 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 glasses, 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 percent on your out-of-pocket costs for frames.

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, behavioral problems, except as specifically provided in the Policy;
2. Biofeedback;
3. Circumcision;
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, including children continuously insured under the preceding student policy issued by this Company; 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 correction surgery, or other treatment for visual defects and problems; except when due to a disease process; or except as specifically provided in the policy;
9. Hearing examinations, except as specifically provided in the Policy, 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, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury;
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
13. 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;
14. Loss sustained or contracted as a consequence of the Insured Person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a Physician;
15. Organ transplants, including organ donation;
16. Pre-existing Conditions of Dependents; except for individuals who have been continuously Insured under the school's student insurance policy for at least 12 consecutive months; or individuals who have been insured under another group policy immediately preceding the individual's Effective Date under this Policy. Credit shall be given to the Insured for satisfaction of the Pre-existing Condition waiting period under the prior policy, or any portion thereof if the prior waiting period has not been satisfied in full;
17. Prescription Drugs, services or supplies as follows, except as specifically provided in the policy;
 - (a) Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use except as specifically provided in the Benefits for Diabetes;
 - (b) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
- (c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except for expenses incurred in prescribing a drug for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it 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; (3) the United States Pharmacopeia Drug Information; or it is recommended by a clinical study or review article in a major peer-reviewed professional journal. Any coverage of a drug shall also include Medically Necessary services associated with the administration of the drug;
- (d) Products used for cosmetic purposes, except as specifically provided in the Policy;
- (e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
- (f) Anorectics - drugs used for the purpose of weight control;
- (g) Sexual enhancement drugs, such as Viagra;
- (h) Growth hormones; or
- (i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
18. Reproductive services including but not limited to: family planning; fertility tests; 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; except as specifically provided in the Benefits for Infertility Treatment;
19. Services provided normally without charge;
20. 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;
21. Sleep disorders;
22. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;
23. Surgical breast reduction, breast augmentation, breast implants, breast prosthetic devices, or gynecomastia; except as specifically provided in the policy;
24. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
25. War or any act of war, declared or undeclared: 1) While the Insured Person is serving in the armed forces of any country; 2) while the Insured Person is serving in any civilian non-combatant unit supporting or accompanying any armed forces of any country or international organization; or 3) while the Insured Person is not serving in any armed forces if the Injury or Sickness occurs outside the 50 states of the United States of America, the District of Columbia, or Canada. A pro-rata premium will be refunded upon request for such period not covered; and
26. 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 Benefits for Treatment of Inherited Metabolic Disease. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

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 newborn 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.
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 spouse, 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 molars 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.

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 *
- Photochromic 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 30% off doctor's usual and customary fees.

GRADUATE STUDENT COLLEGE HEALTH INSURANCE PLAN NEW JERSEY SCHOOL OF OSTEOPATHIC MEDICINE

Take advantage of the Graduate Student College Health Insurance program. Whether you will be participating for the first time or renewing coverage, we urge you to carefully review the insurance plans and keep this brochure for reference throughout the year.

Underwritten By:

Medical

UnitedHealthcare Insurance Company
P.O. Box 809025
Dallas, TX 75380-9025

Dental

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

Vision

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Arranged By:

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

Osteopathic medical and allied health care profession students of the New Jersey School of Osteopathic Medicine are eligible to participate in the Graduate Student College Health Insurance Program.

Any questions regarding the Graduate Student College Health Insurance program should be directed to our broker/consultant, Mass Marketing Insurance Consultants, Inc. (MMIC) at 1-800-349-1039.

This brochure is not a contract of insurance. Terms and conditions of coverage and benefits are set forth in Master Policies underwritten by UnitedHealthcare Insurance Company (Medical), based on Policy COL-06-NJ-INJSICK (Rev. 07-08), United Concordia Life And Health Insurance Company (Dental), and VSP (Vision).

Only Available to Residents of New Jersey

HOW TO APPLY

Enroll On-Line at www.somainsurance.com

Or

- 1) Complete and Sign the Enrollment form on Page 14. Applicants who choose the credit card or check-o-matic method of payment must also complete the Monthly Automatic Enrollment Form (Page 15).
- 2) Payment Options (Refer to Premiums On Page 13)

Applicants Who Wish To Have Their Monthly Premiums Charged To Their Credit Card

- a) Complete the Enrollment Form (Page 14) and Monthly Automatic Enrollment Form (Page 15)
- b) Do not send any payment - premium will be charged to your Master Card or VISA Credit Card

Applicants Who Wish To Have Their Monthly Premiums Debited From a Checking Account

- a) Complete the Enrollment Form (Page 14) and Monthly Automatic Enrollment Form (Page 15)
- b) Send 2 checks; 1st check equal to the monthly payment payable to Mass Marketing Insurance Consultants, Inc. and the 2nd check marked "void" and unsigned.

Send enrollment form, check(s), and Monthly Automatic Pay Plan form (if applicable) to:
Graduate Health Insurance Plan • P.O. Box 95 • Orland Park, IL 60462

MOST FREQUENTLY ASKED QUESTIONS ABOUT THE GRADUATE HEALTH INSURANCE PLAN

- 1) **Can I switch plans during the school year?**
No - the plan you enroll in cannot be changed until September 1, 2010.
- 2) **Is there a pre-existing condition limitation under the medical program?**
Only for dependents. Pre-existing Conditions are not covered for the first 12 consecutive months following an Insured person's effective Date of coverage. However, the time an Insured Person was covered under previous group coverage will be credited if previous coverage immediately preceded the individual's Effective Date under this Policy. A Pre-existing Condition means: a condition which existed for which the Insured Person received treatment or medical advice from a Physician or used prescription drugs within the 6 months prior to the Insured's effective date of coverage. 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 UnitedHealthcare StudentResources. It is your responsibility to file a claim and provide written notice of your claim within 90 days from the date of any treatment. (UnitedHealthcare StudentResources, P.O. Box 809025, Dallas, TX 75380-9025).
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.

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	\$164	\$98	\$16	\$38
Age 30 & Over	\$195	\$116		
SPOUSE ONLY				
Under Age 30	\$354	\$198	\$9.30	\$32
Age 30 & Over (Based on Student's Age)	\$426	\$237		
CHILDR(REN)				
Under Age 30	\$262	\$159	\$16.50	\$43
Age 30 & Over	\$262	\$159		

PAYMENT OPTIONS**Applicants Who Wish To Have Their Monthly Premiums Charged To Their Credit Card**

- 1) Complete the Enrollment Form (Page 14) and Monthly Automatic Enrollment Form (Page 15)
- 2) Do not send any payment - premium will be charged to your MasterCard or VISA Credit Card
- 3) You may wish to enroll on line - www.somainsurance.com

Applicants Who Wish To Have Their Monthly Premiums Debited From a Checking Account

- 1) Complete the Enrollment Form (Page 14) and Monthly Automatic Enrollment Form (Page 15)
- 2) Send 2 checks; 1st check equal to the monthly payment payable to Mass Marketing Insurance Consultants, Inc. and the 2nd check marked "void" and unsigned.

DIRECT BILL OPTION AVAILABLE – CALL 1-800-349-1039

