



STUDENT OSTEOPATHIC MEDICAL ASSOCIATION

COLLEGE HEALTH INSURANCE PROGRAM FOR NYCOM MEMBERS 2009-2010 SCHOOL YEAR

Choice of 2 Medical Plans Now Available To

- 1) **Osteopathic Medical Students**
- 2) **Associate Members** (Any student of an allied health care profession associated with one of the American Osteopathic Association recognized College of Osteopathic Medicine).

HIGHLIGHTS

- ▲ **Acceptance is Guaranteed**
- ▲ **Medical Plan Rx Card – UnitedHealthcare Network Pharmacies
Copays for Plan 1 - \$15 Tier 1/\$25 Tier 2**
- ▲ **Doctor Office Visit Copay - \$25 (Plan 1)**
- ▲ **Medical Plan National PPO Network – UnitedHealthcare
Options PPO**
- ▲ **Vision Plan Option**
- ▲ **Dental Plan Option**

On Line Enrollment Available - www.somainsurance.com

SOMA COLLEGE HEALTH INSURANCE PROGRAM

TABLE OF CONTENTS

	Page(s)
Important Information on the Medical Insurance Program	3
Plan 1 - Medical Insurance Schedule of Benefits	4
Plan 2 - High Deductible Medical Insurance Schedule of Benefits	5
Medical Plan Prescription Drug Card	6
AD&D Schedule of Benefits	7
Optional Dental Plan	7
Optional Vision Plan	8
Medical Insurance Exclusions	9
Dental/Vision Insurance Exclusions	10-11
How The SOMA Plan Works	12
How To Apply	13
Premium Rates	14
Enrollment Form	16
Monthly Automatic Pay Plan	17

**Any Questions On
The SOMA College Health Plan
Call Toll-Free
800-349-1039
8:00 A.M. - 5:00 P.M.
Central Standard Time**

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



IMPORTANT INFORMATION ON THE SOMA COLLEGE MEDICAL INSURANCE PLANS

For a number of years, the Student Osteopathic Medical Association has provided its members with a health insurance program which served as an alternative to school insurance programs. The Board of Trustees has approved significant and substantial changes since inception of the plan. The SOMA College Health Insurance Plan now offers two medical insurance alternatives, in addition to a dental and vision insurance option.

PLEASE NOTE: After the deductible, the accident and sickness (medical) insurance plan has an 80%/60% co-insurance feature, however, we would like to call your attention to the maximum limits per policy year for Plans 1 and 2, also outlined on pages 4 and 5 in this brochure. **The deductible for Plan 1 does not apply to 1) Prescription Drugs which has a \$15 copay Tier 1/\$25 copay Tier 2. The copay under Plan 1 is subject to the \$600 maximum; 2) Wellness Benefit; 3) Doctor Office Visit In-Network. Under Plan 2 (High Deductible) - a \$2,000 deductible for Preferred Providers and \$4,000 Deductible Out-of-Network must be satisfied before the plan pays any covered charges.**

	Plan 1 Co-Pay Plan		Plan 2 High Deductible Plan (HDHP)	
	Preferred Provider	Out-of-Network	Preferred Provider	Out-of-Network
Deductible	\$250	\$500	\$2,000	\$4,000
Inpatient Covered Charges	80% up to \$1,500/day	60% up to \$1,500/day	80%	60%
1. Hospital Expense	50%	50%	50%	50%
2. Doctor's Fee for 2 nd surgical procedure performed after primary surgery	of primary	of primary	of primary	of primary
3. Pre-Admission Testing	\$1,500	\$1,500	80%	60%
Outpatient Benefit Max	80% up to	60% up to		
1. Day Surgery	\$1,500	\$1,500	80%	60%
2. Out Patient Miscellaneous	\$2,000	\$2,000	80%	60%
3. Injections	\$1,500	\$1,500	80%	60%
4. Prescription Drugs (Per Policy Year)	\$600	No Benefits	80%	80%
5. Durable Medical Equipment	\$1,500	80% up to \$1,500	80%	80%

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 New York.

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 16 must be completed and signed.
- 3) Members who wish to pay monthly must complete the Monthly Automatic Pay Plan form on Page 17.

We urge you to carefully review the insurance plans described in this booklet on Pages 4-5. 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 FOR 2009-2010 POLICY YEAR
(Will Not Exceed Usual & Customary Charges)**

Plan 1 (2009-200408-6)

SICKNESS AND INJURY BENEFITS (all benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise noted)	Preferred Provider	Out-of-Network
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	\$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 Allowance for Preferred Providers and 100% of Usual & Customary for Out-of-Network for covered medical expenses. Does not include per service co-pays or deductibles. Per service benefit maximums still apply.	\$9,750	\$9,750
Covered Charges - Inpatient Benefits 1. Room & Board/ Hospital Miscellaneous - \$1,500 Aggregate max per day..... 2. Intensive Care..... 3. Routine Newborn Care – (4 days hosp.confinement expense max as mandated by State of NY) 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 (Mental and Nervous Disorder, Biologically Based Mental Illness and Children with Serious Emotional Disturbance).....	1. Preferred Allowance 2. Paid under R&B/Hosp.Misc. 3. Paid as any other sickness 4. Paid under R&B /Hosp. Misc. 5. Preferred Allowance 6. Preferred Allowance 7. 25% of Surgery Allowance 8. Preferred Allowance 9. Preferred Allowance 10. Preferred Allowance 11. As mandated by State of New York	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. As mandated by State of New York
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 (includes chiropractic care) 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 (Mental and Nervous Disorder, Biologically Based Mental Illness and Children with Serious Emotional Disturbance)..... 15. Prescription Drugs (\$600 maximum per policy year), (after a \$15 tier 1/\$25 tier 2 Copay per prescription.,up to 31 day supply. After the per prescription Copay utilizing a *UHPS pharmacy, the policy Deductible does not apply). Mail order prescription drugs through UHPS at 2.5 times the retail copay up to a 90 day Supply.	1. Preferred Allowance 2. Preferred Allowance 3. Preferred Allowance 4. 25% of Surgery Allowance 5. Paid under Outpatient Misc./ \$25 copay/deductible per visit 6. Preferred Allowance 7. Preferred Allowance 8. 80% of Preferred Allowance 9. Paid under Outpatient Misc. 10. Paid under Outpatient Misc. 11. Paid under Outpatient Misc. 12. Preferred Allowance 13. Paid under Outpatient Misc. 14. As mandated by State of New York 15. \$15 copay tier 1/ \$25 copay tier 2 when utilizing the UHPS Pharmacy (\$600 max).	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. 80% of 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. As mandated by State of New York 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) \$500 max..... 4. Consultant..... 5. Needle Stick/Face Splash as a result of course work..... 6. Cat Scan/MRI..... 7. Chemical Dependency (Alcoholism/Drug Abuse)..... 8. Maternity (as mandated by the St. of New York)..... 9. Elective Abortion..... 10. Complications of Pregnancy..... 11. Repatriation..... 12. Medical Evacuation..... 13. AD&D..... 14. Interscholastic Sports..... 15. Home Health Care..... 16. Wellness Benefit 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, Gonorrhea, Chlamydia test, hemocult for women over the age of 50, a hemoglobin and urine test (not subject to the policy deductible) Pap smear is payable as mandated by the State of New York, but will not be subject to the deductible.	1. 80% of Usual & Customary Charges 2. 80% of Usual & Customary Charges 3. 80% of Usual & Customary Charges 4. Preferred Allowance 5. Paid as any other Sickness 6. Paid Under Outpatient Misc. 7. As mandated by the St. of NY 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 max 14. No Benefits 15. Preferred Allowance 16. Usual & Customary Charges *Except as otherwise specified.	1. 80% of Usual & Customary Charges 2. 80% of Usual & Customary Charges 3. 80% of Usual & Customary Charges 4. Usual & Customary Charges 5. Paid as any other Sickness 6. Paid Under Outpatient Misc. 7. As mandated by the St. of NY 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 max 14. No Benefits 15. Usual & Customary Charges 16. Usual & Customary Charges

SCHEDULE OF BENEFITS FOR 2009-2010 POLICY YEAR (Will Not Exceed Usual & Customary Charges)	Plan 2 – High Deductible Health Plan (HDHP) (Plan 2009-201305-2)	
SICKNESS AND INJURY BENEFITS (all benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise noted)	Preferred Provider	Out-of-Network
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	\$4,000 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 \$8,000 out-of-pocket, this plan pays for 100% of Preferred Allowance for Preferred Providers and 80% of Usual & Customary for Out-of-Network for covered medical expenses.	\$8,000	\$8,000
Covered Charges - Inpatient Benefits 1. Room & Board /Hospital Miscellaneous..... 2. Intensive Care..... 3. Routine Newborn Care(4days hosp confinement expense max as mandated by State of NY).... 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- (Mental and Nervous Disorder, Biologically Based Mental Illness and Children with Serious Emotional Disturbance).....	1. Preferred Allowance 2. Paid under R&B/Hosp Misc . 3. Paid as any other Sickness 4. Paid under R&B/Hosp.Misc . 5. Preferred Allowance 6. Preferred Allowance 7. 25% of Surgery Allowance 8. Preferred Allowance 9. Preferred Allowance 10. Preferred Allowance 11. As mandated by State of New York	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. As mandated by State of New York
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 includes chiropractic care)..... 6. Physiotherapy (all chiropractic care is payable under physician's visits)..... 7. Medical Emergency..... 8. X-rays & Laboratory..... 9. Radiation Therapy..... 10. Tests & Procedures..... 11. Injections..... 12. Chemotherapy..... 13. Psychotherapy (Mental and Nervous Disorder, Biologically Based Mental Illness and Children with Serious Emotional Disturbance)..... 14. Prescription Drug (\$2,500 maximum per policy year – Benefits include contraceptives)....	1. Preferred Allowance 2. Preferred Allowance 3. Preferred Allowance 4. 25% of Surgery Allowance 5. Preferred Allowance 6. Preferred Allowance 7. Preferred Allowance 8. Preferred Allowance 9. Preferred Allowance 10. Preferred Allowance 11. Preferred Allowance 12. Preferred Allowance 13. As mandated by State of New York 14. 80% of Usual & Customary	1. Usual & Customary Charges 2. Usual & Customary Charges 3. Usual & Customary Charges 4. 25% of Surgery Allowance 5. Usual & Customary Charges 6. Usual & Customary Charges 7. 80% of Usual & Customary Charges 8. Usual & Customary Charges 9. Usual & Customary Charges 10. Usual & Customary Charges 11. Usual & Customary Charges 12. Usual & Customary Charges 13. As mandated by State of New York 14. 80% of Usual & Customary
Covered Charges - Other Benefits 1. Ambulance..... 2. Durable Medical Equipment..... 3. Dental (Benefits for injury to Sound Natural Teeth)..... 4. Consultant..... 5. Needle Stick/Face Splash as a result of course work..... 6. Cat Scan/MRI..... 7. Chemical Dependency (Alcoholism/Drug Abuse)..... 8. Maternity (as mandated by the State of New York)..... 9. Elective Abortion..... 10. Complications of Pregnancy..... 11. Repatriation..... 12. Medical Evacuation..... 13. AD&D..... 14. Interscholastic Sports..... 15. Home Health Care..... 16. CAT Scan/MRI..... 17. Wellness Benefit..... 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, gonorrhea, Chlamydia test, hemocult for women over the age of 50, a hemoglobin and urine test. Pap smear is payable as mandated by the State of New York.	1. 80% of Usual & Customary Charges 2. 80% of Usual & Customary Charges 3. 80% of Usual & Customary Charges 4. Preferred Allowance 5. Paid as any Other Injury or Sickness 6. Preferred Allowance 7. As mandated by the State of New York 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 max 14. No Benefits 15. Preferred Allowance 16. Preferred Allowance 17. Preferred Allowance *Except as otherwise specified	1. 80% of Usual & Customary Charges 2. 80% of Usual & Customary Charges 3. 80% of Usual & Customary Charges 4. Usual & Customary Charges 5. Paid as any other Injury or Sickness 6. Usual & Customary Charges 7. As mandated by the State of New York 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 max 14. No Benefits 15. Usual & Customary Charges 16. Usual & Customary Charges 17. Usual & Customary Charges

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 certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable 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 for the most up-to-date tier status.

\$15 copay per prescription order or refill for a **Tier 1** Prescription Drug up to 31 day supply
\$25 copay per prescription order or refill for a **Tier 2** Prescription Drug up to 31 day supply
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 of 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.

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 limits.
- 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, except as required by state mandate.

Definitions

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Prescription Drug List means a list that categories 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 1-877-417-7345.

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) <ul style="list-style-type: none"> • Exams • All X-rays • Cleanings • Fluoride Treatments • Sealants • Palliative Treatment 	100%	100%
Class II Dental Plan Payment (no waiting period, deductible applies) <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • 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.

This brochure is not a contract of insurance. Terms and conditions of coverage and benefits are set forth in a Master Policy issued to Student Osteopathic Medical Association. These plans are underwritten by UnitedHealthcare Insurance Company of New York (Medical), based on Policy Form COL-06-NY (Rev 07-07), United Concordia Life And Health Insurance Company (Dental), and VSP (Vision).

Mass Marketing Insurance Consultants, Inc. specializes in developing and marketing insurance programs for members of professional and trade associations and is SOMA's health insurance broker and consultant. Benefits may vary by state or coverage may not be available.

This plan is only available to New York Residents

MEDICAL EXCLUSIONS

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. 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;
7. 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;
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 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 the Insured was covered under Creditable Coverage which was continuous to 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. Services provided normally without charge by the Student Health Center of the Policyholder, or services covered or provided by the student health fee;
15. Routine Newborn Infant Care, well-baby nursery and Physician charges, except as specifically provided in the Benefits for Maternity Expenses;
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 New York Insurance law) and;
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).

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.
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 joint 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.

HOW THE SOMA COLLEGE HEALTH PLAN WORKS...

Because of the high cost of medical care, students are searching for health insurance programs designed to meet their needs and budget. The SOMA College Medical Insurance Plan has been offered since 1996 to students as an alternative to school programs. It helps keep health care affordable and provides members with the freedom to choose any doctor or healthcare provider when Medical care is needed.

The SOMA College Medical Insurance Plan is a Preferred Provider Organization (PPO) Managed Care Health Plan.

A PPO provides incentives for members to receive care from network doctors, but also covers a percentage of costs if a patient goes outside the network. **The Managed Care Network for the SOMA College Medical Insurance Plan is UnitedHealthcare Options PPO.** The doctors and other health care providers who belong to UnitedHealthcare Options PPO Network are called Preferred Providers. They include general practitioners and internists as well as specialists, hospitals, and other health care facilities. The UnitedHealthcare Options PPO Network has Preferred Providers located locally as well as nationally.

To find a Preferred Provider, you can use UnitedHealthcare's online service at www.myuhc.com. You can find out whether a specific provider belongs to UnitedHealthcare Options PPO Network or find Preferred Providers practicing in your area.

Using UnitedHealthcare's Preferred Providers will save you money because Preferred Providers agree to accept negotiated fees that may be lower than what Non-Preferred Providers would charge. UnitedHealthcare's Preferred Providers do not charge more than the negotiated fee for a given service. For Non-Preferred Providers, the SOMA Plan pays benefits for usual and customary charges only. If a Non-Preferred Provider charges more than the usual and customary charge allowance, you must pay the difference.

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

Underwritten By:

Medical

UnitedHealthcare Insurance Company of New York
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

HOW TO APPLY

Enroll On-Line at www.somainsurance.com

Or

- 1) Complete and Sign the Enrollment form on Page 16. Applicants who choose the credit card or check-o-matic method of payment must also complete the Monthly Automatic Enrollment Form (Page 17).
- 2) Payment Options (Refer to Premiums On Page 14)

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

- a) Complete the Enrollment Form (Page 16) and Monthly Automatic Enrollment Form (Page 17)
- 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 16) and Monthly Automatic Enrollment Form (Page 17)
- 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:
SOMA College Health Insurance Plan • P.O. Box 95 • Orland Park, IL 60462

MOST FREQUENTLY ASKED QUESTIONS ABOUT THE SOMA COLLEGE 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 SOMA program?**
Yes. Pre-existing Conditions are not covered for the first 12 months following an Insured Person's enrollment date under the policy. 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 enrollment 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 UnitedHealthcare Insurance Company of New York. It is your responsibility to file a claim and provide written notice of your claim within 90 days from the date of any treatment or as soon as reasonably possible. (UnitedHealthcare Insurance Company of New York, 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 16) and Monthly Automatic Enrollment Form (Page 17)
- 2) Do not send any payment - premium will be charged to your Master Card 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 16) and Monthly Automatic Enrollment Form (Page 17)
- 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



