

**TABLE OF CONTENTS**

**ELIGIBILITY** .....3

**EFFECTIVE AND TERMINATION DATES** .....4

    Refund of Premium .....5

    Handicapped Children .....5

    Insurance Cost .....5

    Extension of Benefits .....6

**DEFINITIONS** ..... 6-7

**DESCRIPTION OF BENEFITS**.....8

    Part A – Benefit Payments .....8

    Part B – Benefit Period.....8

    Part C – Covered Medical Expenses ..... 8-10

    Part D – Mandated Benefits .....8

    Schedule of Benefits ..... Center

    Part E – Accidental Death and  
    Dismemberment Indemnity ..... 16

**EXCLUSIONS AND LIMITATIONS**..... 16-18

    Continuously Insured ..... 18

    Preexisting Condition Limitation.....18

    Subrogation .....19

**EMERGENCY MEDICAL AND TRAVEL ASSISTANCE** .....19

**GENERAL PROVISIONS** .....19

**CLAIM PROCEDURE**.....21

    Managed Care Grievance Procedure .....22

    External Appeal Process .....22

**VISION BENEFITS** .....23

**CERTIFICATE OF BLANKET STUDENT HEALTH INSURANCE**  
(Non-Participating)  
Issued by:  
**Nationwide Life Insurance Company**  
**Columbus, Ohio**

In this certificate, an Insured Person will be referred to as “You” or “Your”. Nationwide Life Insurance Company will be referred to as “We”, “Us”, or “Our”. Other important words and terms are defined in the section on Definitions.

We have issued a Blanket Student Health Insurance Policy to St. John’s University. This certificate establishes that You and certain Dependents, if Dependents coverage is available and selected, are covered by the described insurance, subject to the terms and conditions of the Master Policy.

This certificate describes the benefits, important provisions, exclusions and the limitations of the Master Policy. This certificate is not the insurance contract. Only the actual provisions for the Master Blanket Policy will control. Insurance under the Master Policy is effective only if You become and remain insured.

The Master Policy has been issued and delivered to St. John’s University.

All periods of insurance will begin and end at 12:01 A.M., local time, at the address of the Policyholder.

**ELIGIBILITY**

All registered undergraduate and graduate students of St. John’s University are eligible to enroll in the basic accident and sickness plan.

All eligible Resident Students are automatically enrolled in the Student Accident and Sickness Plan unless they can provide evidence of equivalent coverage satisfactory to St. John’s University.

Enrollment is mandatory for all International Students with a current passport and student Visa (J-1 or F-1) who are temporarily located outside their home country and are actively engaged in education or educational research activities at St. John’s University.

**\*\*\*For all international students admitted prior to Fall 2006\*\*\***

If you are covered by another medical insurance plan with comparable benefits to this plan, you may request a review of your plan for a possible refund of the charge. However, you must prove that your other insurance will be in effect for the full academic year August 15, 2009 to August 15, 2010. Should your coverage terminate, your account will be billed for the St. John’s University student insurance. Present your proof of equivalent coverage by mail, fax or e-mail to:

**Student Financial Service Center**  
St. John’s University  
Bent Hall  
8000 Utopia Parkway  
Queens, NY 11439  
**FAX: (718) 990-8284**  
**EMAIL: [crawforp@stjohns.edu](mailto:crawforp@stjohns.edu)**

**State in the upper right hand corner of the documentation: HEALTH INSURANCE WAIVER REQUEST. NAME, STUDENT ID X#, AND TELEPHONE NUMBER.**

(Logo here)

**STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN**

Designed Especially for the Students of St. John’s University 2009-2010

Certificate of Coverage  
Underwritten by:  
**Nationwide Life Insurance Company**  
Columbus, Ohio

Policy Number: 302-053-3107

**IMPORTANT NOTE**

This brochure provides a brief description of the important features of this Policy. Terms and conditions of the coverage are set forth in the Policy. We will notify Covered Persons of all material changes to the Policy. Please keep this material with your important papers.

**NONDISCRIMINATORY**

Health care services and any other benefits to which a Covered Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.

To be an Insured Person under the Policy, You must have paid the required premium and Your name, student number and date of birth must have been included in the declaration made by St. John's University or the Administrative Agent to Us. You must actively attend class for at least the first 31 days of the period for which coverage is purchased, except in the case of medical withdrawal. We maintain Our right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that the Policy eligibility requirements have not been met, Our only obligation is a pro-rata refund of premium. You may also insure, on a Voluntary Participation Basis, Your eligible dependents, including Your spouse who is residing with You and Your unmarried children under age 19 who are not self-supporting and reside with You. If You enroll your dependents, You must enroll them for the same term of coverage for which You enroll. Dependent coverage (except for newborn infants) must be applied for at the same time You enroll. Note, however, that a newborn child will be covered for Accident, Sickness and congenital defects from birth until the 31st day after birth. During this 31 days, We must receive written notice of the birth and any required premium that may be necessary for coverage to continue. The last date for enrollment is 10/5/09 for the Fall term and 2/5/10 for Spring term.

**EFFECTIVE AND TERMINATION DATES**

Your coverage will become effective on the later of: 1) 12:01 A.M., Local Time, on August 15, 2009, or January 1, 2010 for second semester enrollees; or 2) The day your premium is received by Us, the School, Our Agent or Administrator.

Coverage for Dependents will become effective on the later of: 1) The Policy Effective Date; 2) The date the Enrollment Form and premium are received by Us, or Our authorized agent when premium is paid within 30 days after the Dependent's arrival in this Country or of your enrollment in the Plan. The effective date of coverage for Dependents will not precede that of the insured student.

Your coverage will terminate on the earliest of the following: 1) The last day of the period for which premium has been paid; 2) 12:01 A.M., Local time, on the Policy termination date; 3) The date You cease to be eligible for insurance under the Policy; 4) The date You depart this Country for Your Home Country; 5) The date the Insured person enters Military Service; or 6) The date the Insured (International) Student ceases to meet visa requirements.

**REFUND OF PREMIUM**

Except for medical withdrawal due to covered Injury or Sickness, We will only refund Your premium if You withdraw from school during the first 31 days of the period for which coverage is purchased. In such case, You will not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid and no refund will be allowed.

You or another Insured Person, who enters the Armed Forces of any country will not be covered under the Policy of the date of such entry. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

**HANDICAPPED CHILDREN**

If You have Dependent coverage and that Dependent ceases to be eligible for coverage because of age, he or she will continue to be an Insured Person so long as the child is and continued to be an Insured Person so long as the child is and continues to be both: 1) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and 2) chiefly dependent upon You for support and maintenance. Proof of such incapacity and dependency must be furnished to Us within 31 days of the child's attainment of the specified age and subsequently as may be required, but not more frequently than annually after the two (2) year period following the child's attainment of the specified age.

**INSURANCE COST**

	Annual 8/15/09 – 8/15/10	Spring/Summer 1/1/10– 8/15/10
Student		
Undergraduate:	\$ 821*	\$ 558*
Graduate:	\$1,099*	\$ 748*
Spouse: Add'l	\$2,876	\$1,928
Child(ren): Add'l	\$1,025	\$ 687

\*An Administrative Cost is included in the Annual & Spring rates.

**EXTENSION OF BENEFITS**

If an insured Person is hospitalized on the date his or her insurance terminates, benefits will continue to be paid until completion of that hospital confinement, not to exceed thirty-one (31) days from such termination date or the maximum Policy benefits, whichever occurs first.

**DEFINITIONS**

These are key words used in the Policy. As You read Your

Certificate, refer to these definitions.

**Accident** means accidental bodily injury sustained by You, that: 1) occurs while Your coverage is in force; and 2) is the direct cause of loss, independent of disease or bodily infirmity. Blood poisoning or septicemia due to accidental bodily Injury is included in the term "accident."

**Biologically Based Mental Illness** means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including, but not limited to: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorders; obsessive compulsive disorders, anorexia and bulimia.

**Children with Serious Emotional Disturbances** means those persons under the age of 18 years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive developmental disorders and one (1) or more of the following: serious suicidal symptoms or other life-threatening self-destructive behaviors; significant psychotic symptoms (hallucinations, delusions, bizarre behaviors); behaviors caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

**Covered Expense** means those expenses incurred or the treatment of an accident and/or sickness that: 1) are incurred on the approval of Physician; 2) do not exceed the Usual and Customary Charges for service or supply provided; and 3) are listed as Covered Expenses in the Benefit Provisions. Expenses that do not meet all of these requirements are not covered.

**Dependent** means 1) Your spouse; or 2) Your unmarried children under 19 years of age. Your Dependent children must reside with You.

A newborn child will be covered for injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth for an initial period of 31 days. To continue coverage beyond this initial 31-day period, the Insured Student must notify Us of the birth and pay any additional premium.

The term "children" includes an Insured Student's adopted children. An adopted child will be considered to be "newly born" to the parents from the date of the signed placement agreement: during any waiting period prior to finalization of adoption; and (from the moment of birth if the insured student takes physical custody of the infant upon such infant's release from the hospital and files a petition to adopt within 30 days of birth, provided that no notice of

revocation to the adoption has been filed and consent to the adoption has not been revoked). It also includes children who lived with the Insured Student in a parent-child relationship.

**Infertility** means either the presence of a demonstrated condition recognized by a Physician and surgeon as a cause of infertility, or the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

**Insured Person** means You, as an eligible student, when You are enrolled for coverage and have paid the required premium. It will also mean a Dependent when You have enrolled that Dependent and paid any required premium.

**International Student** means You if You have a current passport and a student Visa and are temporarily residing outside Your home country while You are actively engaged, on a full time basis, as a student or in educational research activities through Your School.

**Loss** means a medical expense caused by a covered Injury or Covered Sickness.

**Medical Emergency** means any Injury or Sickness involving acute pain or infection that requires immediate medical attention. Medical emergency includes, but is not limited to, broken bones, lacerations, and acute respiratory distress.

**Physician** means a practitioner of the healing arts operating within the scope of his or her license. He or she may not be an Immediate Family Member.

**Pre-existing Condition** means a condition for which medical consultation, advice or treatment was recommended by or received from a Physician during the six (6) months immediately preceding the Enrollment Date of an Insured Person's coverage.

**Sickness** means illness or disease first diagnosed or treated after insurance becomes effective. "Sickness" includes pregnancy that commences during a Term of Insurance.

**Usual, Reasonable and Customary** means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a: 1) like service by a provider with similar training or experience; or 2) supply that is identical or substantially equivalent. The final determination of a usual, reasonable and customary charge rest with Us.

## DESCRIPTION OF BENEFITS

### PART A – BENEFIT PAYMENTS

We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to Injury or Sickness. All injuries or Sicknesses due to the same or related causes will be considered one (1) Injury or one (1) Sickness. Benefits payable

are subject to: 1) the Maximum Benefit for a Covered Injury and Sickness; 2) any specified benefit maximum amounts; 3) any Deductible amounts; 4) any coinsurance amount; and 5) any co-payments.

The Deductible, the Aggregate Maximum Benefit, any specified benefit maximums, coinsurance percentages, or co-payment amounts are shown in the Schedule of Benefits. This Schedule will also indicate whether or not benefits are payable for both injury and Sickness or just for Injury Only.

The first treatment of a covered Injury must begin within 90 days of the date of Injury. The total benefit payable for all Covered Medical Expenses will never exceed the Aggregate Maximum Benefit shown in the Insurance Information Schedule. We will not pay for expenses incurred that do not meet the definition of Covered Expense. The Covered Medical Expenses for an issued Policy will be only those listed in the Benefits Schedule.

### PART B – BENEFIT PERIOD

A benefit period begins when the Insured Person experiences a Loss due to a Covered Injury or Sickness. The benefit period terminates at the end of the period defined in the Insurance Information Schedule. Any extension of a benefit period, if provided elsewhere in this Policy, is limited to medical treatment of the Injury or Sickness that is ongoing on the termination date of the Insured Person's coverage.

The Insured Person's termination date of coverage as it would apply to any other Injury or Sickness will not be affected by such extension.

### PART C – COVERED MEDICAL EXPENSES

**Basic Sickness and Accident Medical Expense Benefit** – Unless otherwise provided in the schedule of benefits, after a \$50 deductible per injury or sickness, we will pay up to a 100% of the Usual, Reasonable and Customary charges incurred for the first \$2,500, then up to 80% of Usual, Reasonable and Customary to the Policy Maximum of \$100,000 for the following Covered Medical Expenses when they are incurred as the result of a covered Sickness, according to the limitations outlines above and in the schedule of benefits.

**The \$50 deductible may be waived if the student receives a referral from the university's Student Health Services or Counseling Center prior to seeking treatment from an outside provider. The student must submit a copy of the Student Insurance Claim Form with appropriate school signatures to provider at time of treatment in order to have the deductible waived.**

**Hospital Room and Board Expense** – We will pay the charges incurred for Hospital room and board at the semi-private room rate.

**Miscellaneous Hospital Expense** – We will pay the charges incurred during a Hospital confinement for each Covered Injury or Sickness for miscellaneous Hospital expenses. These expenses include: 1) anesthesia; 2) use of an operating room; 3) laboratory tests; 4) X-ray examinations; 5) medications; 6) casts and temporary surgical appliances.

**Physician's Fees** – We will pay the non-surgical services of a Physician. Services may be provided on an inpatient or outpatient basis.

**Surgical Expense Benefits** (in or out of hospital) – We will pay charges incurred for a surgical procedure performed on either an inpatient or outpatient basis. This benefit includes charges that are incurred for the services of an Anesthetist.

**Miscellaneous Outpatient Expenses** (excluding surgery) – We will pay the charges actually incurred for miscellaneous outpatient expenses (excluding surgery) incurred for the treatment and care of a Covered Injury of Sickness. Expenses must be incurred on the advice of a Physician. Miscellaneous outpatient expenses include diagnostic X-ray and laboratory tests and other reasonable expenses for services and supplies that have been prescribed by the attending Physician.

**Prescription Drugs** – We will pay the charges incurred for prescription drugs as outlined in the Schedule of Benefits. When a benefit for prescription drugs is included in the Schedule of Benefits, this benefit will include coverage for prescribed drugs approved by the Food and Drug Administration of the United States for the treatment of certain types of cancer even if such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration. Such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in an established reference compendium.

Eligible prescriptions must be filled at an Express Scripts participating pharmacy. Covered Persons will be given an ID card to show the pharmacy as proof of coverage. No claim forms need to be completed once this ID card is received. Until the card is received, eligible prescriptions may be filled, and claims will be paid on a reimbursement basis. Submit a completed Express Scripts claim form to the address provided on the form. Express Scripts claim forms and a list of participating pharmacies can be obtained by calling Express Scripts at (800) 332-5455 or by visiting their website at: [www.express-scripts.com](http://www.express-scripts.com).

**Dental Treatment** - We will pay the charges incurred, for treatment resulting from the accidental Injury to Sound, Natural

Teeth, up to a maximum of \$100 per tooth.

**Ambulance Expense** – We will pay the charges incurred for the use of a professional Ambulance Service for emergency transportation as indicated in the Schedule of Benefits.

**Emergency Room Expense** – We will pay the charges incurred when the use of a Hospital emergency room is required for the emergency treatment of a Covered Injury or Sickness.

**Mental and Nervous Expense** – We will pay the charges incurred for the treatment of a mental or nervous condition as follows:

**Inpatient** – Paid as any other sickness, up to a 60-day maximum.

**Outpatient** – Paid as any other sickness, up to a maximum of 20 visits.

**Inpatient Alcoholism and Substance Dependency Treatment Expense** – We will pay the charges incurred for the diagnosis and treatment of alcoholism or alcohol abuse and substance abuse or substance dependency. We will pay such benefit as follows; 1) Detoxification benefits as a result of alcohol dependence or substance dependence – inpatient benefits in a Hospital or detoxification facility of 7 days of active treatment in a consecutive 12-month period; and 2) Rehabilitation services – limited to 30 days of inpatient care in a consecutive 12-month period.

Such services must be provided by facilities in New York State that are certified by the Division of Alcoholism and Alcohol Abuse with the Division of Substance Abuse Services and, in other states, to those which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism or substance abuse programs. See mandated benefits section for Outpatient Treatment of Alcoholism and Substance Abuse benefit.

**Medical Evacuation Expense** (International Students and/or Dependents Only) – If an Insured Person is unable to continue their academic program as the result of a Covered Injury or Sickness occurring while he or she is covered under this Policy, We will pay the necessary reasonable and customary charges, not to exceed the specified benefit shown in the Schedule of Benefits, for evacuation to another medical facility of the Insured Person's home country. A medical evacuation would be considered only if medically necessary, and after a Hospitalization of at least 5 days. Any expenses payable under this benefit require approval of the attending Physician as well as Ours.

**Repatriation Expense** (International Students and/or Dependents Only) – In the event of the death of an Insured Person, while he or she is covered under this Policy, We will pay the necessary reasonable and customary charges, not to exceed the specified benefit shown in the Schedule of Benefits, for preparation and transportation of the remains to the Insured Person's place of

residence in his or her home country. Any benefits payable under this provision require Our prior approval.

#### **PART D – MANDATED BENEFITS**

All Policy provisions, including benefit maximums, coinsurance amounts, limitations, exclusions and general Provisions apply unless specifically stated otherwise.

**Maternity Care** – We will pay benefits for maternity care, including Hospital, surgical or medical care, to the same extent that coverage is provided for illness or disease is covered under the policy. Such care other than coverage for Complications of Pregnancy, will include: 1) Not less than two (2) payments, at reasonable intervals and for services rendered, for prenatal care, and a separate payment for delivery and postnatal care; 2) Inpatient Hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours after a caesarean section. Maternity care coverage will include the services of a licensed midwife who is affiliated or practicing in conjunction with a facility licensed according to public health law. We will NOT pay for duplicative routine services actually provided by both a licensed midwife and a Physician; 3) Parent education, assistance and training in breast or bottle feeding; and 4) The performance of any necessary maternal and newborn clinical assessments; 5) If the mother should elect to be discharged earlier than the time frame in item 1 of this provision, the inpatient benefit will include at least one (1) home care visit that will be in addition to any home health care coverage available under this policy. Such a visit may be requested at any time within 48 or 96 hours of the time of delivery and will be delivered within 24 hours of either the mother discharge or of the time of the mother's request, whichever is later. This visit will not be subject to deductibles, coinsurance or copayments.

**Home Health Care** - If, as the result of a covered Injury or Sickness, an Insured Person requires any of the home health care services, as defined, We will pay the reasonable charges incurred for such services, less a \$50 per school year deductible. Expenses for such services must be incurred within 156 weeks (3 years) from the date of the Injury or the start of a covered Sickness. The maximum number of home health care visits is limited to 40 in any period of 12 consecutive months.

This benefit does not cover: 1) services furnished outside the State of New York unless they are rendered by an entity licensed to provide Home Health Care in the state where the services were rendered; 2) persons who are not residents of the State of New York; 3) persons who are eligible for Medicare due to age; 4) services which are not part of a Home Health Care plan;

5) services provided by an immediate family member of an Insured Person or a member of an Insured Person's household; 6) custodial care or transportation; or 7) any period during which an Insured Person was not under the care of a Physician.

**Diabetes Equipment, Supplies and Service** - When Sickness coverage is provided under the Policy, we will pay a benefit for expenses incurred for the following equipment, supplies and services in the treatment of diabetes. Equipment and supplies that may be medically necessary for the treatment of diabetes include, but are not limited to the following: 1) Lancets and automatic lancing devices; 2) Glucose test strips; 3) Blood glucose monitors; 4) Blood glucose monitors for visually impaired; 5) Control solutions used in blood glucose monitors; 6) Diabetes data management systems for management of blood glucose; 7) Urine testing products for glucose and ketones 8) Oral anti-diabetic agents used to reduce blood sugar levels; 9) Alcohol swabs; 10) Syringes; 11) Injection aids including insulin drawing up devices for the visually impaired; 12) Cartridges for the visually impaired; 13) Disposable insulin cartridges and pen cartridges; 14) All insulin preparations; 15) Insulin pumps and equipment for the use of the pump including batteries; 16) Insulin infusion devices; 17) Oral agents for treating hypoglycemia such as glucose tablets and gels; 18) Glucagon for injection to increase blood glucose concentration; 19) Other diabetes equipment and related supplies that are medically necessary for the treatment of diabetes.

We will also pay Usual and Customary charges for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets.

This benefit will be limited to visits medically necessary upon the diagnosis of diabetes, where a Physician diagnoses a significant change in the Insured Person's symptoms or conditions that necessitate changes in an Insured Person's self-management or where reeducation or refresher education is necessary. Coverage also includes home visits when medically necessary.

Such education may be provided by: 1) the Physician or other licensed health care provider legally authorized to prescribe under Title 8 of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment; or 2) a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral of a Physician or other licensed health care provider. Education provided by the certified diabetes nurse educator, certified nutritionist or registered dietitian is limited to group settings wherever practicable.

**Outpatient Treatment of Alcoholism and Substance Abuse** - If an Insured Person incurs charges for the diagnosis and treatment

of chemical abuse and dependency. We will pay the reasonable charges incurred for such treatment. The maximum number of outpatient visits is limited to 60 in any period of 12 consecutive months. Twenty (20) of these visits may be used as family member visits. Only one (1) visit per day is covered. "Visit" means diagnostic medical or therapeutic services or comprehensive, day or clinic visits. For family members, visits include counseling and education. Socialization visits are not covered.

Treatment and services must be provided: 1) in New York State, by facilities that are certified by the Division of Alcoholism and Alcohol Abuse or the Division of Substance Abuse Services; or 2) in other states, by facilities that are accredited by the joint commission on accreditation of Hospitals as alcoholism or substance abuse treatment programs.

**Second Medical Opinion** - We will pay the expenses incurred for a second medical opinion by an appropriate specialist, including but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

**Breast Cancer Benefit** - 1) Hospitalization benefits will be payable for such period of time as determined by the attending Physician in consultation with the patient to be medically appropriate when the patient is undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the Policy. Such treatment will be subject to any annual deductible and coinsurance amounts shown in the Schedule of Benefits; 2) We will pay the expenses incurred for breast reconstructive surgery following a covered mastectomy as follows: a) All stages of reconstruction of the breast on which the mastectomy has been performed; and b) Surgery and reconstruction of the other breast to produce a symmetrical appearance. Such reconstructive surgery will be in the manner determined by the attending Physician and the patient to be appropriate.

**Enteral Formula Benefit** - When an issued policy covers prescription drugs, as part of that benefit, We will pay the expenses incurred for the cost of enteral formulas for home use when prescribed by a Physician or other licensed health care provider. Any prescription from the Physician or licensed health care provider must state the use of such formulas is clearly Medically Necessary and has been proven effective as a disease specific treatment for an Insured Person who is or who will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death.

Enteral formulas which are Medically Necessary and taken under written prescription from a Physician for the treatment of specific diseases will be distinguished from nutritional supplements taken electively. Specific diseases for which enteral formulas have been proven effective include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn's Disease; gastroesophageal reflux with failure to thrive; disorders of the gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which, if left untreated, will cause malnourishment, chronic physical disability, mental retardation and death.

Coverage for certain inherited diseases of amino acid and organic acid metabolism will include modified solid food products that are low protein or which contain modified protein which are Medically Necessary. Such coverage for any continuous 12-month period for any Insured Person will not exceed \$2,500.

**Chiropractic Care Benefit** - We will pay the expenses incurred for chiropractic care, performed by a doctor of chiropractic, to the same extent as would be payable for Physician's services in a Physician's office. Chiropractic care must be in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

**Experimental or Investigational Treatment or Clinical Trials Expense** - We will pay the expenses incurred for patient care service furnished in connection with experimental or investigational treatments or as part of a clinical trial. Coverage for the services required under this benefit are provided subject to the terms and conditions generally applicable to other benefits provided under the Policy.

**Cancer Screening Tests** - We will pay the charges incurred for the following cancer screening tests. 1) Mammography screening for occult breast cancer as follows: a) Upon the recommendation of a Physician, a mammogram at any age upon the recommendation of a Physician, a mammogram at any age for Insured Persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer; b) A single baseline mammogram for covered persons age 35 to 39 inclusive; c) An annual mammogram for covered persons age 40 and older. 2) Annual cervical cytology screening (PAP tests) for cervical cancer and its precursor states for women age 18 years and older as recommended by a Physician. 3) Prostate cancer screening, as follows: a) Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific

antigen test at any age for men having a prior history of prostate cancer; and b) An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer factors.

**Prehospital Emergency Medical Services** - We will pay the expenses incurred for prehospital emergency medical services for the treatment of an emergency condition when such services are provided by a certified ambulance service.

**Cancer Prescription Drug Expenses** - When the policy to which this Endorsement is attached includes a benefit for prescription drugs, this benefit will include the expenses incurred for prescription drugs used for the treatment of cancer. This includes coverage of drugs that have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one (1) of the following established reference compendia: 1) The American Medical Association Drug Evaluations; 2) The American Hospital Formulary Service Drug Information; or 3) The United States Pharmacopeia Drug Information; or 4) Recommended by review articles or editorial comment in a major peer reviewed professional journal. Coverage will not be provided for any experimental or investigational drugs of any drug which the Food and Drug Administration has determined to be contra-indicated for treatment of the specific type of cancer for which the drug has been prescribed.

**Children with Serious Emotional Disturbances and Biologically Based Mental Illnesses Benefits** - Covered Medical Expenses are payable as any other sickness.

**Bone Mineral Density Tests** - We will pay Covered Medical Expenses for bone mineral density measurements, tests, drugs and devices approved by the Federal Food and Drug Administration or generic equivalents as approved substitutes. These Benefits will be paid according to the criteria of the Federal Medicare program as well as in accordance with the criteria of the National Institutes of Health, including, as consistent with such criteria, dual energy x-ray and absorptiometry.

Covered Medical Expenses will be paid according to the criteria of the Federal Medicare program as well as in accordance with the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, Your qualifying for Benefits shall at a minimum, include You:

- previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

- with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or
- on a prescribed drug regimen posing a significant risk of osteoporosis; or
- with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or
- with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

**End of Life Care Expenses** – Covered Medical Expenses include care provided at an Acute Care Facility that specializes in the treatment of terminally ill patients diagnosed with advanced cancer. Reimbursement for services is provided at 100% of the Negotiated Charge. In the absence of a Negotiated Charge, reimbursement is provided at 100% of the acute care facility's reimbursement rate under the Medicare program, after any applicable Deductible.

If We disagree with the admission of or the provision of the continuation of care for the Covered Person by the facility, We will initiate an expedited External Appeal in accordance with External Appeal provision in the Policy. Until a decision is rendered on this Appeal, We will provide Benefits, subject to the provisions of this Policy. The decision of the External Appeal agent is binding on the Covered Person and Us.

**PART E - ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY**

We will pay the amount shown if an Insured Person sustains any of the following losses as the result of a covered Accident.

Loss of Life .....	\$5,000
Loss of two (2) or more members.....	\$5,000
Loss of one (1) member .....	\$2,500

Member means hand, foot or eye. Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. Loss of a thumb and index finger means the complete severance through or above the joints between the fingers and the hand.

**EXCLUSIONS AND LIMITATIONS**

The Policy does not cover loss nor provide benefits for:

1. International Students Only - expenses incurred while in the students home country, however coverage will be provided in Canada and Mexico;
2. Preventive medicines, serums or vaccines of any kind; routine physical or other examinations where there are no objective indications of impairment of normal health;

3. Dental care or treatment, except for such care and treatment due to accidental injury to sound, natural teeth within 12 months of the accident and except for care and treatment due to congenital disease or anomaly;
4. Professional services rendered by an Immediate Family Member or any who lives with You;
5. Services or supplies not necessary for the medical care of an Insured Person's Injury or Sickness;
6. Services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury;
7. Foot care in connection with corns, calluses, flat feet, fallen arches, week feet, chronic foot strain or symptomatic complaints of the foot;
8. Cosmetic surgery or treatment for congenital anomalies, except for reconstructive surgery as the result of a Covered Injury or Sickness or a congenital disease or anomaly of a covered Dependent child that resulted in a functional defect. Correction of a deviated nasal septum is considered cosmetic surgery unless it results from a Covered Injury and is necessary for its treatment;
9. Birth control, including elective surgical procedures or devices, except as mandated by the State;
10. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid;
11. Treatment of nervous or mental disorders or treatment of alcoholism or drug addiction except as provided for in the Schedule of Benefits;
12. Any expenses in excess of Usual, Reasonable and Customary charges;
13. Loss incurred as the result of riding as a passenger or otherwise in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world;
14. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority;
15. Loss resulting from playing, practicing, traveling to or from, or participating in, any intercollegiate, club or professional sports, except as provided in the Insurance Information Schedule;
16. Intentionally self-inflicted Injury, attempted suicide or suicide, while sane or insane;
17. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national

- government or any of its agencies, except when a charge is made which the Insured Person is required to pay;
- 18. Services that are duplicated when provided by both a certified nurse-midwife and a Physician;
- 19. Expenses payable under any prior Policy which was in force for the person making the claim;
- 20. Expenses incurred during a Hospital emergency room visit unless the Insured reasonably believes the situation to be of an emergency nature;
- 21. Services and/or supplies that are not related to the care and treatment of an Injury or Sickness;
- 22. Expenses incurred after: a) the date insurance terminates as to the Insured Person; b) the Maximum benefit for each Covered Injury or Sickness has been attained; or c) the end of the Benefit Period specified in the Benefit Schedule;
- 23. Charges incurred for medically necessary physical therapy, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided for in the Schedule of Benefits;
- 24. Accident resulting from the Insured's committing or attempting to commit an assault or felony or participation in a riot or civil disorder;
- 25. Accident resulting from the Insured's use of alcohol or any drugs unless taken on the advice of a Physician; and
- 26. Treatment provided in a government hospital.

**CONTINUOUSLY INSURED**

Any Insured Person who has continuous coverage under this Plan or any Prior Plan from one (1) year to the next shall be covered for conditions first manifesting themselves while Continuously Insured, except for benefits payable under prior policies in the absence of this Plan. Prior Plan means the Student Health Insurance Policy or policies issued to St. John's University immediately before the Policy. It also means any previous health insurance plan where the Insured Person was continuously covered which was in effect not more than 60 days prior to the effective date of coverage under this Plan.

**PRE-EXISTING CONDITION LIMITATION**

The Policy does not cover Pre-existing Conditions during the first 12 months of continuous coverage.

However, this provision will not limit benefits for a Pre-existing Condition if, during the period immediately preceding the Insured's becoming insured under the Policy, he or she was enrolled as a member under another Policy or plan that provided similar benefits for twelve (12) consecutive months (10 months for pregnancy).

Prior coverage of less than twelve (12) months (10 months for pregnancy) will be credited toward satisfying the preexisting condition limitation. This waiver of the preexisting condition limitation will be effective provided the Insured becomes eligible and applies for coverage under the Policy within 63 days of the termination of his or her prior coverage.

#### **SUBROGATION**

In the event that the insured suffers an Injury or Illness for which another party may be responsible, such as someone injuring the insured in an accident, and the Company pays benefits as a result of that Injury or Illness, the Company will be subrogated and succeed to the insured's right of recovery against the party responsible for the insured's illness or injury to the extent that the settlement of judgment received from the third party specifically identifies or allocates monetary sums directly attributable to expenses for which the Company has paid benefits. This means that the Company has the right, independently of the Insured, to proceed against the party responsible for your injury or illness to recover the benefits the Company has paid.

#### **EMERGENCY MEDICAL AND TRAVEL ASSISTANCE**

MEDEX Assistance Corporation provides you with a comprehensive program with 24/7 emergency medical assistance including emergency evacuation and repatriation and other travel assistance services when you are 100 or more miles away from home. Your MEDEX identification card is your key to travel security.

**For general inquiries regarding your international assistance coverage, please call Consolidated Health Plans at (800) 633-7867.**

**If you have a medical or travel problem, simply call MEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: (800) 527-0218 or if you are in a foreign country, call collect at: (410) 453-6330.** If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

#### **GENERAL PROVISIONS**

**Entire Contract/Changes** - This policy, with the application and attached papers, is the entire contract between Us and the Policyholder. No change in the Policy will be effective until approved by one (1) of our officers. This approval must be noticed on or attached to the policy. No agent has the authority to change the policy or waive any of its provisions.

**Notice of Claim** - Written notice of claim for loss must be given within 30 days after loss starts or as soon as reasonably possible. The notice can be sent to Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, MA 01104. Notice should include the Insured Person's name and policy number.

**Claim Forms** -When We receive the notice of claim, We will send forms for filing proof of loss. If these forms are not sent within 15 days, the proof of loss requirements will be met by giving Us a written statement of the nature and extent of loss within the time stated in the Proofs of Loss provision.

**Proofs of Loss** - If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to us within 90 days after the end of each period for which We are liable. If it was not reasonably possible to give us written proof in the time required, We will not reduce or deny a claim for this reason if the proof is filed as soon as reasonably possible.

**Time of Payment of Claim** - After receiving written proof of loss, We will pay all benefits then due within 60 days after receipt of such proof.

**Payment of Claim** - Subject to any written direction of the Insured Person in an application or otherwise, any benefits provided by the Policy may, at Our option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the provider rendering services. It is not required that the service be rendered by a particular hospital or health care provider.

Benefits for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then in effect, any death benefit will be payable to the estate of the Insured Person. Any other accrued benefits unpaid at the Insured Person's death may, at Our option, be paid either to such beneficiary or to the Insured Person's estate.

If benefits are payable to the estate of an Insured Person or to a person not legally competent to give a valid release, We can pay benefits up to \$1,000 to someone related to the Insured Person by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

**Physical Examination and Autopsy** - We, at Our expense, have the right to have an Insured Person examined as often as reasonably necessary while a claim is pending. We, at Our expense, may also have an autopsy made unless prohibited by law.

**Legal Actions** - No legal action may be brought to recover on the Policy prior to 60 days after written proof of loss has been given as required by the policy. No such action may be brought after two (2) years from the time written proof of loss is required to be given.

**Conformity with State Statutes** - Any provision of the Policy that, on its Effective Date, is in conflict with the laws of the state in which it is issued is amended to conform to the minimum requirements of such laws.

**Assignment** - We do not assume the responsibility for the validity of an assignment.

**Waiver of Our Rights** - The following will not operate as a waiver of Our right in defense of any claim arising under the Policy: a) Our acknowledgment of the receipt of notice given under the Policy; or b) the furnishing of forms for filing proofs of loss; or c) the acceptance of such proof; or d) the investigation of any claim hereunder.

**Choice of Physician** - You or an Insured Person will have free choice of legally qualified Physician or health care provider.

**Non-Participating** - This policy is non-participating. It does not share in our profits or surplus earnings.

#### **CLAIM PROCEDURE**

In the event of injury or illness, the Insured Person should:

1. If at St. John's University, report immediately to the Health Office so that proper treatment can be prescribed or approved, and obtain a claim form; or if away from St. John's University, consult a Doctor and follow his/her advice and obtain a claim form from the Health Office as soon as possible.
2. Notify the Claims Administrator within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible.
3. Claim forms and instructions are available at the Health Office in DaSilva Hall, first floor, or in the Health Office, Campus Center, Room B19, Staten Island.
4. Complete the claim form in full and sign it.
5. The completed claim form should be mailed within 90 days from the date of Injury, or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible.

Retain a copy for your records and mail a copy to the Claims Administrator, Consolidated Health Plans, at the address shown.

6. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills should be mailed promptly to the Claims Administrator at the address below. No additional claim forms are needed as long as the Insured Person's/Student's name and identification number are included on the bill.
7. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to the Claims Administrator, Consolidated Health Plans, at the address shown.

**To Appeal a Claim** – Send a letter stating the issues of the appeal to Consolidated Health Plans' Appeal Department at the address shown. Include your name, address, school attended and email address, if available.

Claims will be reviewed and responded to within 60 days by Consolidated Health Plans.

**REMEMBER THAT EACH INJURY OR SICKNESS IS A SEPARATE CONDITION AND A SEPARATE CLAIM FORM IS REQUIRED FOR EACH CONDITION**

**MANAGED CARE GRIEVANCE PROCEDURE**

Please refer to the policy for complete details on the Managed Care Grievance Procedure, Medical Review and External Appeal Procedure which is on file at Student Health Services.

**EXTERNAL APPEAL PROCESS**

Please refer to the online version of this brochure, located at [www.chpstudent.com](http://www.chpstudent.com), for the full text of the External Appeal Process.

**Claims Administrator:**  
Consolidated Health Plans  
2077 Roosevelt Avenue  
Springfield, MA 01104  
(800) 633-7867

[www.chpstudent.com](http://www.chpstudent.com)  
[info@consolidatedhealthplan.com](mailto:info@consolidatedhealthplan.com)

**Underwritten by:**  
Nationwide Life Insurance Company  
**Policy Number: 302-053-3107**

**Servicing Broker:**  
University Health Plans, Inc.  
One Batterymarch Park • Quincy, MA 02169-7454  
(800) 437-6448  
[www.universityhealthplans.com](http://www.universityhealthplans.com)  
[info@univhealthplans.com](mailto:info@univhealthplans.com)

**Representations of this plan must be approved by the Company.**

This is not the Policy. Rather it is a brief description of the benefits and other provisions of the Policy. The Policy is governed by the laws and regulations of the State of New York. This is a New York only contract that will be in compliance with New York laws.

For a copy of the Company's privacy notice, go to:  
[www.chpstudent.com](http://www.chpstudent.com)

**For Vision Discount Benefits please go to:**  
[www.consolidatedhealthplan.com/student\\_health](http://www.consolidatedhealthplan.com/student_health)

**ST. JOHN'S UNIVERSITY**  
**Student Accident and Sickness Insurance Plan**

**ENROLLMENT FORM**  
**2009-2010**

1. Please print the following information:

---

Student's Last Name	First	Middle
---------------------	-------	--------

---

Permanent Mailing Address - Street

---

City	State	Zip Code
------	-------	----------

---

Social Security Number or School ID Number	Date of Birth
--	---------------

2. Please check the appropriate box(es) for the coverage desired:

**ANNUAL ENROLLMENT:**  
**(8/15/09-8/15/10)**

- |                       |                                   |
|-----------------------|-----------------------------------|
| Student Undergraduate | <input type="checkbox"/> \$ 821*  |
| Student Graduate      | <input type="checkbox"/> \$1,099* |
| Spouse                | <input type="checkbox"/> \$2,876  |
| Child(ren)            | <input type="checkbox"/> \$1,025  |

**SECOND SEMESTER ENROLLMENT:**  
**(1/01/10-8/15/10)**

- |                       |                                  |
|-----------------------|----------------------------------|
| Student Undergraduate | <input type="checkbox"/> \$ 558* |
| Student Graduate      | <input type="checkbox"/> \$ 748* |
| Spouse                | <input type="checkbox"/> \$1,928 |
| Child(ren)            | <input type="checkbox"/> \$ 687  |

\*An Administrative Cost is included in the Annual & Spring rates.

3. List Dependents on reverse.
4. Make your check or money order (in U.S. dollars able to be drawn on a U.S. Bank or U.S. bank affiliate) payable to:

**Nationwide Life Insurance Company**

5. Mail this form with your check or money order to:

**University Health Plans, Inc.**  
**One Batterymarch Park**  
**Quincy, MA 02169-7454**