Student Accident and Sickness Insurance Program

Designed for the
Graduate Students of

STEVENS
Institute of Technology

2006-2007
NATIONWIDE LIFE INSURANCE COMPANY
COLUMBUS, OHIO
Policy Number: 302-064-2904
Effective August 18, 2006 to August 18, 2007

IMPORTANT NOTICE

This brochure provides a brief description of the important features of the Policy. It is not a 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.

THIS CERTIFICATE IS SUBJECT TO THE LAWS OF THE STATE OF NEW JERSEY.

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WHERE TO FIND HELP

For questions about:

- Insurance Benefits
- Claims Processing
- Lost ID Cards (x137)

Please contact:
Consolidated Health Plans
195 Stafford Street
Springfield, MA 01104-3503
(800) 633-7867
www.consolidatedhealthplan.com

For questions about:

- Enrollment
- Waiver/Enrollment Process

Please contact:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Phone: (800) 437-6448
Fax: (617) 472-6419
www.universityhealthplans.com
Email: info@univhealthplans.com

To Students:

I am pleased to announce that Stevens has selected University Health Plans to provide a student health insurance plan for 2006-2007. This 12 month plan is effective from August 18, 2006 to August 18, 2007. Also, students can purchase optional catastrophic accident and injury coverage (see details on page 8).

New Jersey law mandates that all full-time students have health insurance. Students are automatically enrolled in the insurance plan and a premium for coverage is added to their tuition bill unless proof of comparable coverage is furnished. Students who have comparable insurance coverage can waive the student plan on-line at www.universityhealthplans.com and selecting Stevens Institute of Technology.

The deadline to process a waiver is September 23, 2006. Waivers must be submitted online. No paper forms will be accepted. Students who waive the plan online will be able to print out a confirmation of their waiver request. If full-time students do not submit a waiver by the deadline, they will be automatically enrolled in the plan.

For many graduate students, including those with F1 visas, the annual premium is $744. Benefits for J-Visa Holders / Exchange Visitors meet U.S. Government requirements.

While graduate students with internationally-based health plans can decline this plan, we recommend that you accept the coverage. Purchasing this student insurance program assures access to local care and eliminates potential problems with plans based outside the US. Enrolled students can also purchase this plan for their spouse and children. Students who are interested in purchasing dependent coverage should obtain a dependent enrollment form on-line or can contact University Health Plans directly at (800) 437-6448.

In addition to the student accident and sickness insurance program, Stevens is pleased to offer our students and their dependents a Dental Insurance Plan (DeltaCare). You may enroll in this plan on a VOLUNTARY basis, it is not required insurance. The on-line enrollment form, plan benefit highlights, and a list of network dentists can be found by linking to www.universityhealthplans.com and selecting Stevens Institute of Technology and then Dental.

Should you have any questions about the on-line waiver process or benefits please contact University Health Plans at 1-800-437-6448.

I wish you all the best for the upcoming school year.

Sincerely,

Joseph Stahley
Assistant Vice President of Student Development

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll free at (800) 633-7867 or visiting us at www.consolidatedhealthplan.com.

Eligibility

New Jersey law mandates that all full-time students have health insurance. These students are automatically enrolled in the insurance plan and a premium for coverage is added to their tuition bill unless proof of comparable coverage is furnished. Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. The Company maintains its right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund the premium.

Eligible students who enroll may also insure their Dependents. Eligible Dependents are the spouse and unmarried children under 19 years of age, who are not self-supporting. Dependent eligibility expires concurrently with that of the Insured Student.

Effective and Termination Dates

The Master Policy on the file at the school becomes effective at 12:01 a.m., August 18, 2006. Coverage becomes effective on that date or the date application and full premium are received by the designated representative acting on behalf of the group insured for remittance to the Company, whichever is later. The Master Policy terminates at 12:01 a.m. August 18, 2007. Coverage terminates on the end of the period through which premium is paid. Dependent coverage will not be effective prior to that of the insured student. Refunds of premium are allowed only upon entry into the armed forces.

If the Dependent is mentally or physically handicapped and incapable of sustaining employment, termination of his or her insurance will be waived. The Company must be furnished proof of these conditions within 31 days after the child attains the limited age for Dependents. You must meet the Eligibility requirements listed above each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the

premium expiration date. It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage.

The Policy is a Non-Renewable One Year Term Policy. It is the Insured's responsibility to obtain coverage the following year in order to maintain continuity of coverage. Insureds who have not received information regarding a subsequent Plan prior to this Certificate Termination Date should inquire regarding such coverage with the school.

How to Enroll

Premium for coverage for all eligible students is automatically added to their tuition bill unless proof of comparable coverage is furnished. Payment for full-time student coverage should NOT be made directly to the company.

If you are interested in obtaining coverage for your dependents and voluntary optional catastrophic supplemental plan, please visit the website at www.universityhealthplans.com or call UHP at 1-800-437-6448.

Premium Rates

Domestic/International Students (non J-Visa Holders) and All Others:

	Annual 8/18/06-8/18/07	Spring 1/8/07-8/18/07	First Summer 5/15/07-8/18/07	Second Summer 7/14/07-8/18/07
Student	$744	$471	$208	$75
Spouse	$1,656	$1,045	$464	$165
All Children	$1,225	$774	$343	$123
Opt. Catast.	$325	$325	$325	$325

Please visit www.universityhealthplans.com to view the J-Visa Holders/Exchange Visitors and Professor/Research Scholars premium rates.

Extension of Benefits After Termination

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Student Health Center (SHC) Referral Required Students Only

The student must use the services of the Health Center first where treatment will be administered, or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral will be issued by visiting the Student Health Center. A referral from the counseling center is required for mental health services rendered outside the center.

A SHC referral for outside care is not necessary only under the following conditions:

1. Medical Emergency. The student must return to SHC for necessary follow-up care;
2. When the Student Health Center is closed;
3. When service is rendered at another facility during break or vacation periods;
4. Medical care received when the student is more than 50 miles from campus;
5. Medical care obtained when a student is no longer able to use the SHC due to a change in student status; or
6. Maternity; or

Newborn Infant Coverage

Newborn Infant means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth on the same basis as any other Dependent children. Benefits for such a child will be for Injury or Sickness paid on the same basis as any other Sickness, including medically diagnosed congenital defects and birth abnormalities.

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

Mammography Benefits

Benefits will be paid on the same basis as for any other Sickness for a mammogram according to the following guidelines:

1. One baseline mammogram for women who are at least thirty-five but less than forty years of age;
2. One mammogram every year, or more frequently if recommended by a Physician, for women age forty and over.

Benefits are subject to any Deductible, coinsurance, limitations, and any provisions of the Policy.

Home Health Care Benefits

Benefits for Home Health Care are hereinafter defined will be paid on the same basis as any other Injury or Sickness.

Home Health Care means those nursing and other home health care services rendered to an Insured who is the patient in his place of residence, under the following conditions:

1. On a part-time and intermittent basis, except when full-time or 24-hour services are needed on a short-term (no more than 3 days) basis;
2. If continuing Hospitalization would otherwise have been required if home health care were not provided;
3. Pursuant to a Physician's written order and under a plan of care established by the responsible Physician working with a Home Health Care Provider. The Physician must review the plan monthly and certify monthly that continued confinement in a Hospital would otherwise be required. That Physician may not be related to the Home Health Care Provider by ownership or contract. All care plans shall be established within 14 days following commencement of home health care; and
4. Home health care services will include benefits for hemophilia, including expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia when the home treatment program is under the supervision of State approved hemophilia treatment center. These benefits shall be provided to the same extent as any other Sickness under the Policy. "Blood product" includes, but is not limited to Factor VIII, Factor IX, and cryoprecipitate. "Blood infusion equipment" includes, but is not limited to, syringes and needles. Home Health Care Provider means an agency which is licensed by the New Jersey Commissioner of Health as a home health agency.

Home Health Care Services means any of the following services which are Medically Necessary to achieve the plan of care referred to in condition (3) above and are provided for the care of the Insured Person: nursing care (furnished by or under the supervision of a Registered Nurse); physical therapy; occupational therapy; medical social work; nutrition services; speech therapy; home health aide services; medical appliances and equipment, drugs and medications, laboratory services and special meals, to the extent such items and services would be covered by this policy if the Insured where

in a Hospital; and any diagnostic or therapeutic service, including surgical services performed in a Hospital outpatient department, a Physician's office or any other licensed health care facility, to the extent such service would be covered by this policy if performed as an inpatient Hospital service, provided that service is performed as part of the plan of care.

Limitations - Home Health Care Benefits are subject to the following limitations:

1. Services must follow a Hospital Confinement of at least 3 consecutive days. Services must begin not more than 3 days after the end of that confinement.
2. Any visit by a member of a home health care team on any day will be considered one home health care visit. Benefits will be provided for no more than 60 home health care visits in any period of 12 consecutive months
3. The amount payable for a home health care visit shall not exceed for each of the first three days on which services are provided the daily room and board benefit provided by this policy during the prior confinement; for each subsequent day of such services, the amount payable shall not exceed one-half of the daily room and board benefit provided by this policy during the prior confinement.
4. The services and supplies must be furnished and charged for by a Home Health Care Provider.

Benefits shall be subject to all Deductibles, coinsurance, copayments, limitations or any other provisions of the Policy.

Audiology and Speech Language Pathology Benefit

Benefits shall be paid on the same basis as for any other Sickness for covered medical expenses that are performed or rendered to the Insured by a Physician for Audiology and Speech Language Pathology.

Benefits are subject to any Deductible, coinsurance, limitations, and any provisions of the Policy.

Treatment of Alcoholism Benefit

Benefits for treatment of Alcoholism will be paid on the same basis as any other Sickness, when such treatment is prescribed by a Physician.

Outpatient treatment for alcoholism shall be paid to the same extent as inpatient treatment if it is provided: 1) at a Hospital or as aftercare at a detoxification facility; 2) by an alcoholism counselor certified by the State of New Jersey; and 3) under a program approved by the New Jersey Division of Alcoholism.

Only with respect to the Alcoholism Benefit, "Hospital" shall include 1) detoxification facilities licensed pursuant to P.L.

1975, C.305 of the laws of New Jersey; and 2) licensed, certified or state approved residential treatment facilities, when the Insured Person is under a program which meets the minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation. Benefits are subject to any Deductible, coinsurance, copayments, limitations, and any provisions of the Policy.

Maternity Benefit

Benefits will be paid for normal pregnancy and normal childbirth as for any other Sickness. Elective abortion is not covered.

Conception must occur after the Insured's effective date. Covered Medical Expenses include: 1) Physician's visits; 2) Diagnostic services; 3) Obstetrical/surgical procedures; 4) Hospital room and board; 5) Hospital miscellaneous expenses; and 6) Routine well-baby care while Hospital Confined not to exceed a maximum of 4 days confinement expense.

Benefits will be paid for at least 48 hours Hospital Confinement following normal delivery and 96 hours Hospital Confinement following cesarean section.

Benefits will be paid for normal pregnancy and normal childbirth as for any other Sickness. Coverage is provided to services performed by and facilities used by licensed certified nurse midwives.

Complications of Pregnancy are covered as any other Sickness.

Maternity Testing

The following maternity routine tests and screening exams will be paid on the same basis as any other Sickness. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in any pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: AFP Blood Screening; Amniocenteses / AFP Screening; and Chromosome Testing. Fetal Stress / Non-Stress tests are payable. Pre-natal vitamins are not covered.

Benefits are subject to any Deductible, coinsurance, copayments, limitations, and any provisions of the Policy.

OPTIONAL CATASTROPHIC MEDICAL COVERAGE

This optional benefit is subject to payment of an additional premium and begins payment after the basic maximum of $25,000 for Domestic Students and $50,000 for J-Visa Holders/Exchange Visitor has been paid by the Company. It must be purchased at the same time the basic coverage is purchased. This benefit is paid at 100% up to an additional $200,000. The total benefit payable for each Injury or Sickness, including the basic benefit is $225,000 for Domestic and $250,000 for J-Visa Holders/Exchange Visitors. This optional benefit is not subject to any pre-existing condition limitations.

Coordination of Benefits Provision

Definitions:

(1) Allowable Expenses: Any necessary, reasonable, and customary item of expense, a part of which is covered by at least one of the Plans covering the Insured Person.

An Allowable Expense to a Secondary Plan includes the value or amount of any Deductible Amount or Coinsurance Percentage or amount of otherwise Allowable Expenses which was not paid by the Primary or first paying Plan.

(2) Plan: A group insurance plan or health service corporation group membership plan or any other group benefit plan providing medical or dental care treatment benefits or services.

Such group coverages include: (a) group or blanket insurance coverage, or any other group type contract or provision thereof; this will not include school accident coverage for which the parent pays the entire premium; (b) service plan contracts, group practice and other pre-payment group coverage; (c) any coverage under labor-management trustees plans, union welfare plans, employer and employee organization plans; and (d) coverage under governmental programs, including Medicare, and any coverage required or provided by statute.

(3) Primary: The Plan which pays regular benefits.

(4) Secondary: The Plan which pays a reduced amount of

benefits which, when added to the Primary Plan's benefits will not be more than the Allowable Expenses.

Effect on Benefits – If an Insured Person has medical and/or drug coverage under any other Plan, all of the benefits provided are subject to coordination of benefits.

During any policy year or benefit period, the sum of the benefits that are payable by Us and those that are payable from another Plan my not be more than the Allowable Expenses.

During any policy year or benefit period, We may reduce the amount We will pay so that this reduced amount plus the amount payable by the other Plans will not be more than the Allowable Expenses. Allowable Expenses under the other Plan include benefits which would have been payable if a claim had been made.

However, if: (1) the other Plan contains a section which provides for determining its benefits after Our benefits have been determined; and (2) the order of benefit determination stated herein would require Us to determine benefits before the other Plan, then the benefits of such other Plan will be ignored in determining the benefits We will pay.
This Plan determines its order of benefits using the first of the following rules which applies:

(1) If your other Plan does not have Coordination of Benefits, that Plan pays first.

(2) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent.

(3) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (B)(3) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

a. the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year; but
b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in a. above, but instead has a rules based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(4) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

1. first, the Plan of the parent with custody of the child;
2. then, the Plan of the spouse of the parent with the custody of the child; and
3. finally, the Plan of the parent not having custody of the child.

(5) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Right to Recovery and Release of Necessary Information – For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery – Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at this time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

Automobile Related Injury Benefit Provision

(in association with the Coordination of Benefits provision)

Definitions

Automobile Related Injury means bodily injury sustained by an Insured Person as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile.

Allowable Expense means any medically necessary, reasonable, and customary item of expense, a part of which is covered by the policy or PIP at least in part as an Eligible Expense.

Eligible Expense means that portion of expense incurred for treatment of an Injury which is covered under the policy without application of any Deductible or coinsurance, if any.

Out-of-State Automobile Insurance Coverage (OSAIC) means any coverage for medical expenses under an automobile insurance policy other than PIP, as PIP is defined herein, including automobile insurance policies issued in another state or jurisdiction.

PIP means Personal Injury Protection coverage (specifically those provisions for medical expense coverage) provided as part of an automobile insurance policy issued in the state of New Jersey.

Application of Benefits

When Covered Medical Expenses are incurred as the result of an Automobile Related Injury, and the injured Insured Person has coverage under PIP or OSAIC, the following sections will be used to determine whether the policy provides coverage that is primary or secondary to auto coverage. These sections will also be used to determine the amount payable if the policy provides primary or secondary coverage.

Determination of Primary or Secondary Coverage

The policy provides secondary coverage to PIP, unless health coverage has been elected as primary coverage by or for the Insured Person covered under the policy. This election is made by the Named Insured under a PIP policy and affects the Dependents of the Named Insured who are not themselves the Named Insured under another auto policy. This policy may be primary for one covered person, but not for another if the persons have separated auto policies and have made different selections regarding primacy of health coverage.

This Certificate is secondary to OSAIC. However, if the OSAIC contains provisions which make it secondary or excess to the Named Insured's Plan, then the Names Insured's Plan will be primary.

Effect on Benefits

If the Named Insured's Plan is primary to PIP or OSAIC, the policy will pay benefits on eligible expenses in accordance with the terms provided in the policy.

If the Named Insured's Plan is one of several insurance plans which provide benefits to the Insured and are primary to automobile insurance coverage, then the rules as provided in the Coordination of Benefits provision endorsement shall apply.

If the Named Insured's Plan is secondary to PIP or OSAIC, the benefits payable will be the lesser of: 1) the remaining uncovered allowable expenses after PIP has provided

coverage after application of any Deductible or coinsurance; or 2) the actual benefits that would have been payable had the Named Insured's Plan been providing coverage primary to PIP.

To the extent that the policy provides coverage that supplements coverage under Medicare, then the Named Insured's Plan can be primary to auto insurance only insofar as Medicare is primary to auto insurance.

Definitions

Adopted Child means the adopted child will be covered from the moment of placement for the first 31 days. The Pre-existing Conditions limitation will not apply to an adoptive child. The Insured must notify the Company, in writing, of the adopted not less than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured's residence.

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

Complications of Pregnancy means: 1) conditions required medical treatment prior to or subsequent to termination of pregnancy, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and 2) non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Covered Medical Expenses means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Maximum Benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under this Certificate; 4)

made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any and 7) incurred prior to the policy Termination Date, except as specifically provided in the Extension of Benefits after Termination provision.

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

Dependent means the spouse (husband or wife) of the Named Insured, and dependent, unmarried children including any child under age 18 for which the Named Insured is under court order to provide coverage. Children shall cease to be a Depended on the first to occur of:

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

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

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

Elective Surgery and Elective Treatment means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective Surgery or Elective Treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; 2) are not recognized and generally accepted medical practices in the United States.

Hospital means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises or on a pre-arranged basis; and 6) is not primarily a clinic nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorder.

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

Injury means bodily Injury of an Insured Person: 1) caused by an Injury which occurs while this Certificate is in force as to that Insured Person; 2) treated by a Physician within 30 days after the date of Injury; and 3) which results directly and independently of all other causes in loss covered by this Certificate.

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

Ingenix, Inc. is a research and consulting firm that focuses on medical coding and reimbursement issues. To determine Usual and Customary Charges, the Company uses MDR's "1974 CRVS Gap-Fill Study". This study fills the coding holes in the 1974 California Relative Value Study with current procedure codes and unit values consistent with the 1974 CRVS.

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

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

Medical Emergency means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in: 1) death; 2) permanent placement of the Insured's health in jeopardy; 3) serious impairment of bodily functions; or 4) serious and permanent dysfunction of any body organ or part.

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

Medical Necessity means those services or supplies provided or prescribed by a Hospital or Physician which are: 1) essential for the symptoms and diagnosis or treatment of the Sickness or Injury; 2) provided for the diagnosis, or the direct care and treatment of the Sickness or Injury; 3) in accordance with the standards of good medical practice; 4) not primarily for the convenience of the Insured, or the Insured's Physician; and , 5) the most appropriate supply or level of service which can safely be provided to the Insured.

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

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

Mental and Nervous Disorder means a Sickness that is a mental, emotional or behavioral disorder. All diagnoses classified as a "Mental Disorder" according to the ICD-9 (International Classification of Diseases, 9th Revision, codes 291 through 319 inclusive) are considered one Sickness.

Negative X-ray means and X-ray that shows the absence of a fracture; pathology; or disease.

PHCS Preferred Provider means a provider in the Private Healthcare Systems network who contracts to provider services at a discounted rate.

Physician means a fully qualified licensed Physician or any provider of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws, other than a member of the Insured's immediate family:

The term "member of the immediate family" means husband, wife, children, father, mother, brother, sister, and the corresponding in-laws.

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

Positive X-ray means an X-ray that shows the presence of a fracture; pathology; or disease.

Pre-existing Condition means a condition which existed for which the Insured Person received treatment or medical advice from a Physician or used Prescription Drugs within 6 months prior to the effective date of the Coverage.

Prescription Drugs means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs, including "off-label" use of FDA-approved drugs which under the applicable state or federal aw may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

Prescription Drugs also means a drug prescribed for treatment which has not been approved by the Food and Drug Administration, if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed in the: 1) American Medical Associated Drug Evaluation; 2) American Hospital Formulary Service Drug Information; 3) United States Pharmacopoeia Drug Information; or is recommended by a clinical study or review article in a major peer-reviewed professional journal.

Prescription Drugs does not mean any experimental or investigational drug; or any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Psychotherapy means the treatment of a Mental and Nervous Disorder. Psychotherapy includes all related or ancillary charges incurred as a result of a Mental and Nervous Disorder.

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

Sickness means Sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this Certificate. All related conditions and recurrent symptoms of the same or similar condition normal activity will be considered one Sickness.

Sound, Natural Teeth means natural teeth, the major portion of which are present, regardless of fillings.

Totally Disabled means a condition of a Named Insured which, because of Sickness or Injury, renders the Insured unable to actively attend classes. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

Usual and Customary Charges means a charge which is: 1) usual and customary when compared with the charges made

for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. No payment will be made under this Certificate for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions and Limitations

No benefit will be paid for loss or expense caused by, contributed to, or resulting from:

1. Services and supplies related to nicotine addiction;
2. Assistant Surgeon Fees;
3. Biofeedback – services and supplies related to biofeedback;
4. Congenital conditions, except as specifically provided for Newborn Infants; circumcision;
5. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn children; hirsutism; nonmalignant warts, moles and lesions;
6. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
7. Elective surgery and elective treatment; elective abortion;
8. Injury sustained while (a) participating in any interscholastic, high school, intramural, club, or intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
9. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
10. Patient controlled analgesia (PCA);
11. Immunizations services and supplies related to immunizations, except as specifically provided in a benefit section; preventative medicines or vaccines; except where required for treatment of a covered Injury;
12. Loss sustained or contracted as a consequence of the Insured Person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a Physician; Drug Abuse;
13. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
14. Mental and Behavioral Problems - services and supplies for conditions related learning disabilities;
15. Organ transplants;
16. Participation in a riot or civil disorder;

17. Pre-existing Conditions as defined in the Policy for a period of 6 months; except for 1) individuals who have been continuously Insured under the school's student insurance policy for at least 6 consecutive months; or, individuals who have been insured under another group policy issued by this Company immediately preceding the individual's Effective Date under this Policy, and the Company paid benefits for the Pre-existing Condition under the preceding group policy. Credit shall be given to the Covered Person for satisfaction of the Pre-existing condition waiting period under the prior school policy, or any portion thereof if the prior waiting period has not been satisfied in full;
18. Prescription Drugs dispensed or purchased while not hospital Confined, except as specifically provided in the Policy;
19. Reproductive infertility services including but not limited to: birth control; family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; premarital examinations; tubular ligation; vasectomy; sexual reassignment surgery; impotence, organic or otherwise; except as specifically provided in the policy;
20. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the Policy;
21. Routine Services or supplies for foot care including care of corns, bunions (except capsular or bone surgery) and calluses;
22. Services provided normally without charge;
23. Services, supplies and/or treatment for acne; acupuncture; allergy, including allergy testing; alopecia;
24. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery;
25. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
26. Sleep disorders, supplies, treatment, or testing relating to sleep disorders;
27. Supplies, except as specifically provided in the Policy;

28. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices; or gynecomastia; other than as specifically provided in the Policy
29. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
30. Vision services and supplies related to eye refractions or eye examinations, eyeglasses except when due to a disease process;
31. 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;)
32. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, surgery for removal of excess skin or fat.

CLAIM PROCEDURE

In the event of Covered Accident or Sickness:

1. Contact Your Student Health Services, if available. If Student Health Services is not available, determine whether a Consolidated Health Plans Preferred Provider is located close by for treatment at reduced cost to You.
2. Itemized billings (Written Proof of Loss) should be submitted by Your health care provider or the Covered Person within 90 days of treatment, or as soon as reasonably possible.

All Claim forms should be submitted to the Claims Administrator shown below:

Claims Administrator:
CONSOLIDATED HEALTH PLANS
195 Stafford Street
Springfield, MA 01104-3503
(413) 733-4540
Toll Free (800) 633-7867

The Plan is underwritten by:
Nationwide Life Insurance Company
Policy Number: 302-064-2904

Within 45 days following receipt of the appropriate documentation, we will either (1) make payment for the services provided, (2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or (3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If we fail to comply, We are required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning 45 days after receipt of the properly documented claim at the rate of 1.5 percent per month, not to

exceed 18 percent per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.
There is no utilization review performed on this policy.

CLAIM APPEAL

To appeal a claim, send a letter stating the issues of the appeal to Consolidated Health Plan's Appeal Department at the above address. Include your name, phone number, address, school attended and email address, if available.
Claims will be reviewed and responded to within 60 days by Consolidated Health Plans.
Translation services are available to assist insureds, upon request, related to administrative services.

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.

This is your Temporary ID card

Detach and Retain for your Records
The Permanent ID Card Will Follow.
2006-2007 Identification Card
Consolidated Health Plans

Insured (Name of Student)
If a premium has been paid, the Student whose name appears above has been insured under a Policy issued to:
Stevens Institute of Technology
Policy Number: 302-064-2904