Group Student Accident and Sickness Insurance Program

POLICY NUMBER: 2008-G3A31

2008–2009

Designed for Undergraduate and Graduate Students of

SETON HALL UNIVERSITY

SOUTH ORANGE, NJ 07079

This Certificate is Subject to the Laws of the State of New Jersey.

Underwritten by
SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK
Binghamton, NY

as policy form # SMLGP-1000

SHU HEALTH SERVICES

Accredited by the Accreditation Association for Ambulatory Health Care

Services Are Available To All Students, However, Health Services Does Not Treat Dependents and Children

Strict confidentiality is maintained.
Hours September - May
Health Professionals on duty:
Monday - Friday 8:45 a.m. - 4:45 p.m.

June - August Health Professionals on duty:
Monday - Thursday 8:30 a.m. - 5:00 p.m.
Friday 8:30 a.m. - 12:30 p.m.
Location
303 Centre Street, South Orange, NJ
Telephone: (973) 761-9175

Services Provided

Allergy Desensitization Injections, according to a schedule and with the allergens provided by your private health practitioner.

Dermatology

Evaluation and Treatment.

General Primary Care

For common health problems, including respiratory tract infections, sexually transmitted diseases, and chronic illnesses such as diabetes and asthma.

Gynecology

Routine pelvic and breast examination,
Routine Pap tests.

Health Education

Self-care health maintenance.

Laboratory Tests

Limited routine diagnostic procedures.

Mental Health

Crisis intervention.

Physical Examinations

Wellness physicals and physicals for participation in college-related programs.

Referral

Will be made to outside specialists as necessary.

Accidental Injuries

Evaluation and Treatment.

A Message from the University:

ACCIDENT AND SICKNESS INSURANCE PLAN

This is a brief description of the Accident and Sickness Insurance Plan available for Graduate and Undergraduate students of Seton Hall University. The Plan is underwritten by Security Mutual Life Insurance Company of New York. The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University during business hours. The Master Policy will control in the event of any conflict between this brochure and the Policy.

ELIGIBILITY

New Jersey State Law requires that all full-time registered students be covered by Health Insurance. In order to comply, Seton Hall University requires all full-time students in on-campus attendance (including student/teachers) to complete the on-line waiver card showing proof of other coverage or purchase this Student Accident and Sickness Insurance Plan.

COST OF INSURANCE

	Per Semester Rates
Student*	$ 309
Spouse	$1,022
Spouse & Child(ren)	$1,651
Child(ren)	$ 629

For new Students not enrolling until the Spring Semester, the cost for the spring Semester only is as follows:

Student*	$ 309
Spouse	$1,388
Spouse & Child(ren)	$2,254
Child(ren)	$ 866

*Student rates include an administrative fee.

POLICY TERM

The insurance under Seton Hall University's Student Accident and Sickness Insurance Plan for the Annual Policy is effective at 12:01 a.m. on August 15, 2008. Coverage for an insured individual will be considered as continuous during consecutive periods of insurance under this plan when premium payments are received by the Company, Plan Administrator or University. The Annual Policy terminates at 12:01 a.m. on August 15, 2009 or at the end of the period through which the premiums are paid.

For new students registered for the Second Semester, coverage is effective at 12:01 a.m. on January 12, 2009 and terminates at 12:01 a.m. on August 15, 2009 or at the end of the period through which the premiums are paid.

DEPENDENT COVERAGE

Students enrolled in the Student Accident and Sickness Insurance Plan may also enroll their dependent children or a spouse who resides with the Insured Student. Children must reside with and be fully supported by the Insured Student. Newborn children will also be covered for injury or sickness, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will automatically continue for 31 days after the date of birth. To continue the coverage beyond the 31 day period, the Insured Student must complete and return the Dependent Enrollment Form with payment. Contact T.L. Groseclose Associates for a Dependent Enrollment Form.

If dependent coverage is provided and the Insured dies while coverage is in effect, dependent coverage will continue for a minimum of 180 days after the death of the insured or to the last day of the period through which the premium is paid, whichever is greater.

PREMIUM REFUND POLICY

Except for a withdrawal due to an injury or sickness, any student withdrawing from the school during the first 31 days of the period for which coverage is purchased shall not be covered under the plan and a full refund of the premium will be made. Students withdrawing after 31 days will remain covered under the plan for the full period for which the premium has been paid and no refund will be made available.

Coverage for an insured student entering the Armed Forces of any country will terminate as of the date of such entry. Those insured students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request within 90 days of the withdrawal from the school. Premium received by the Company is fully earned upon receipt.

MEDICAL EXPENSE BENEFITS

Benefits are provided up to $50,000 for Covered Medical Expense incurred, inpatient or outpatient, as the result of a covered accidental injury or sickness. The initial treatment for an accidental injury must be rendered within 30 days of the accident. Benefits for a covered injury or sickness are limited to treatment received during the term of the Policy.

The Company will pay for the reasonable and necessary services in accordance with the usual and customary charge normally made for such services.

Benefits for maternity are payable on the same basis as a sickness, provided conception occurs during the period of coverage under the Policy. Benefits are payable for childbirth even though coverage may lapse, if conception occurred while coverage was in force with respect to the insured.

Inpatient and Outpatient Benefits

Inpatient Room & Board & ICU - up to the daily semi-private room rate, including General nursing care given and charged for by the hospital. Benefits for confinements resulting from a mastectomy will not be limited to less than the following: Radical - minimum of 72 hours; Simple - minimum of 48 hours.

Inpatient Hospital Miscellaneous - for expenses incurred while Hospital Confined or as a precondition for being Hospital Confined. Miscellaneous Expenses include, but are not limited to: the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies.

Outpatient Miscellaneous - for outpatient Hospital and Physician's services. Outpatient services payable under this benefit will be designated "Paid Under Outpatient Miscellaneous Benefit" in the Benefit Schedule.

Inpatient or Outpatient Surgery - for Physician's (other than the attending Physician) fees for inpatient surgery, based on the Medical Data Research (MDR) Schedule for the Usual & Customary Expense. Two or more surgical procedures performed at the same time and through the same incision will be deemed one surgery, the surgery with the highest benefit. Covered Medical Expenses will be paid under this inpatient surgery benefit or under the outpatient surgery benefit, but not both.

Outpatient Day Surgery Miscellaneous - for the charges incurred on the day of outpatient surgery for services and supplies such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs or medicines, therapeutic services and supplies. The surgery may be performed in a Hospital emergency room, trauma center, Physician's office, clinic, or ambulatory surgical center.

Inpatient Anesthetist - for Physician's' fees in connection with an inpatient surgery.

Outpatient Anesthetist - for the services of a professional anesthesiologist or of an anesthetist under the supervision of a Physician for the purposes of administering anesthesia.

Private Duty RN - for private duty nursing care services when they are ordered by a Physician as a Medical Necessity. Services must be provided by a Nurse who is not a regular staff member of the Hospital in which the Insured is confined. General nursing care given by the hospital is not covered under this benefit.

Inpatient Physician's Visits - for medical care and treatment by a Physician (other than a surgeon) while the Insured is Hospital confined. Benefits are limited to one visit

per day. If the Insured also requires outpatient treatment by a Physician on the same day, benefits will be paid under only one of the two benefits.

Outpatient Physician's Visits - for visits to the Insured's Physician, benefits are limited to one visit per day. This benefit does not apply when related to surgery or Physiotherapy. Benefits are payable under the outpatient benefit or under the inpatient benefit for Physician's Visits, but not both on the same day.

Outpatient Physiotherapy - for the charges incurred for one visit per day.

Emergency Room - for the charges incurred if the Insured requires the use of an emergency room and any supplies used during treatment.

Outpatient Tests and Procedures - for diagnostic tests and medical procedures performed by a Physician. This does not include regular Physician's visits, Physiotherapy, X-rays and laboratory procedures.

Outpatient Laboratory Procedures - for the charges incurred for laboratory procedures. These procedures are only those identified in the Physician's Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive.

Inpatient Psychotherapy - for the charges incurred for Psychotherapy, including the charges for the treatment of a Biologically-based Mental Illness, as specified in the Insurance Information Schedule, on the same basis as any other Illness. Benefits are limited to one visit per day.

Outpatient Psychotherapy (Mental & Nervous) - We will pay the charges incurred for psychotherapy, including the charges for the treatment of a Biologically-based Mental Illness, as specified in the Insurance Information Schedule, on the same basis as any other Illness. Benefits are limited to one visit per day.

Other Benefits

Prescription Drugs - as defined by the policy and as listed in the Schedule of Benefits.

Consultant - for the services of a Consulting Physician when the same has been requested and approved by the attending Physician.

Dental Treatment - made necessary by Injury to Sound, Natural Teeth and that is performed by a Physician. Routine dental care and treatment to the gums are not covered.

Maternity - up to the Usual and Customary charges to the same extent as any other illness with a minimum stay of 48 hours for vaginal delivery and 96 hours for caesarean section.

Mandated Benefits

Alcoholism Treatment Benefit - if the Insured requires treatment for alcoholism, the Company will pay the Usual and Customary charges for such treatment to the same extent as for any other covered Sickness. Treatment must be prescribed by an M.D. and provide benefits for inpatient or outpatient care in a licensed Hospital; treatment at a licensed detoxification facility; confinement as an inpatient or outpatient at a licensed, certified or state approved residential treatment facility. Such treatment must be certified or accredited by a nationally recognized organization, or licensed by the State of New Jersey.

The total number of benefit days under this provision may not exceed the total number of benefit days provided for any other Sickness under the contract. Treatment or confinement at any facility will not preclude further or additional treatment at any other eligible facility.

Childhood Immunizations - if coverage for Dependent children is provided under the Policy, for the charges for all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Health Service and the New Jersey Department of Health and Senior Services. Benefits will be provided to the same extent as for any other medical condition under the Policy, except that no deductible will apply for benefits provided under this provision.

Diagnostic Examination Coverage - for the charges incurred in conducting an annual medically recognized diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test. The test must be for men who are age 50 and over who are asymptomatic; or age 40 and over who have a family history of prostate cancer or other cancer risk factors to the same extent as any other medical condition under the Policy.

Home Health Care Benefits - for Covered Medical Expenses when the Insured requires Home Health Care. Covered Expenses under this benefit are limited to the following: Up to 60 Home Health Care Visits in any continuous 12 month period; and for Other Home Health Care Services as defined, but not to exceed the amount the Policy would have paid if the Insured had been hospitalized.

Lead Poisoning Screening for Children - if coverage for dependent children is provided under the Policy, for screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health and Senior Services; and medical evaluation and any necessary medical follow-up and treatment for lead poisoned children. Benefits will be provided to the same extent as any other medical condition

under the policy except that no deductible may be applied for benefits provided under this provision.

Mammography - for a low dose mammography of the breast according to the following schedule: a baseline mammogram for insured women ages 35 through 39; a mammogram every year for women ages 40 and over; and in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman's health care provider.

Pap Smears - for charges incurred in conducting a Pap smear to the same extent as for any other medical condition under the Policy.

Reconstructive Breast Surgery - following a mastectomy to the same extent as for any other Sickness, including but not limited to: the cost of prostheses; the expenses incurred for surgery to restore and achieve symmetry between the two breasts; and if the coverage issued to the Policyholder provides outpatient x-ray or radiation therapy, the cost of outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer will be included as part of the outpatient x-ray or radiation therapy coverage.

Treatment of Wilm's Tumor - to the same extent as for any other Sickness, including an autologous bone marrow transplant when standard chemotherapy treatment is unsuccessful, notwithstanding that any such treatment may be considered experimental or investigational.

Treatment of Diabetes - for equipment and supplies the Company will pay the charges incurred If an Insured incurs expenses for any of the following equipment and supplies used in the treatment of diabetes. a) blood glucose monitors and blood glucose monitors for the legally blind; b) data management systems; c) test strips for glucose monitors and visual reading and urine testing strips; d) insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto; e) insulin infusion devices; and oral agents for controlling blood sugar.

For Self-Management Education - the Company will pay the charges incurred for diabetes self-management education that is necessary to ensure that the Insured is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet. This benefit is limited to visits that are medically necessary upon: a) the diagnosis of diabetes; b) diagnosis of a significant change in the covered person's symptoms or conditions that necessitate changes in the Insured's self-management; and c) the determination that reeducation or refresher education is necessary. Diabetes self-management education will be provided by a dietician registered by a nationally recognized professional association of dieticians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the state qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

Therapeutic Treatment of Inherited Metabolic Diseases - including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be medically necessary by the Insured's Physician. The following definitions apply to this benefit: Inherited Metabolic Diseases means a disease caused by an inherited abnormality of body chemistry for which testing is mandated, including hypothyroidism, galactosemia, phenylketonuria, and other preventable biochemical disorders that may cause mental retardation or other permanent disabilities.

Low Protein Modified Food Product means a food product that is and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. This does not include a natural food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and that is formulated to be consumed or administered eternally under the direction of a Physician.

Treatment of Cancer; Bone Marrow Transplants - for the treatment of cancer by dose intensive chemotherapy; autologous bone marrow transplants; and/or peripheral stem cell transplants. Such treatments must be performed by an institution approved by the National Cancer Institute or pursuant to protocols consistent with guidelines of the American Society of Clinical Oncologists.

Dental Treatment for Severely Disabled or Children - for general anesthesia and hospitalization for dental services; or a medical condition covered by the Policy which requires hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services were performed. This benefit is limited to treatment of an Insured Person who is severely disabled or to a Dependent child age five or under.

Infant Formulas - When the policy covers the expenses incurred in the purchase of prescription drugs, coverage will also be provided for the expenses incurred in the purchase of specialized non-standard infant formulas. The covered infant's Physician must have diagnosed the infant as having multiple food protein intolerance. The Physician must determine such formula to be medically necessary when the first covered infant has not been responsible to trails to standard non-cow milk based formulas, including soybean

and goat milk. The Company will pay the expenses for such formulas to the same extent as for any other prescribed items under the policy.

Colorectal Cancer Screening - for: 1) Persons age 50 and over; and 2) Persons of any age who are considered to be at high risk for colorectal cancer. The methods for screening will include: 1) A screening fecal occult blood test; 2) Flexible sigmoidoscopy, colonoscopy, barium enema or any combination thereof; or 3) The most reliable, medically recognized screening test available. The method and frequency of screening to be used will be in accordance with the most recent published guidelines of the American Cancer Society and as determined medically necessary by the Insured Person's Physician, in consultation with the Insured Person. As used in this benefit, **high risk for colorectal cancer** means a person has: 1) A family history of: a) Familial adenomatous polyposis, b) Hereditary non-polyposis colon cancer, c) Breast, ovarian, endometrial or colon cancer or polyps; 2) Chronic inflammatory bowel disease; or 3) A background, ethnicity or lifestyle that the Physician believes puts the person at elevated risk for colorectal cancer. Benefits will be provided to the same extent as for any other medical condition under the policy.

Audiology and Speech Language Pathology - The Company will pay the expenses incurred as the result of a Covered Injury or Covered Sickness for audiology and speech language pathology services. Such services must be determined by a Physician to be medically necessary and must be performed or rendered to an Insured Person by a licensed audiologist or speech language pathologist within the scope of his or her practice.

Biologically Based Mental Illness Benefit - The Company will pay the expenses incurred for the treatment of a Biologically Based Mental Illness on the same basis as for any other covered Sickness.

As it pertains to this benefit, biologically based mental illness means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the Covered Person with the Illness. Biologically based mental illness includes, but is not limited to the following: 1) schizophrenia; 2) schizoaffective disorder; 3) manic depressive disorder; 4) bipolar disorder; 5) paranoia and other psychotic disorders; 6) obsessive-compulsive disorder; 7) panic and pervasive developmental disorder; or 8) autism.

Any exclusion regarding such treatments, if any, is hereby deleted so long as such services or supplies are not experimental or investigational.

Wellness Health Examinations - Benefits will be provided under the Policy for expenses incurred by the Insured for any of the following tests in connection with a Wellness Health Examination. The benefit amount payable will be as specified in the policy. 1) For all Insureds 18 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level and blood cholesterol level, or alternatively, low density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level; 2) For all Insureds 35 years of age or older, a glaucoma eye test every five years; 3) For all Insureds 40 years of age or older, an annual stool examination for presence of blood; 4) For all Insureds 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years; 5) For all women 18 years of age or older, a pap smear every two years; 6) For all women 40 years of age or older, an annual mammogram examination, unless the Policy also includes a mammography benefit; 7) For all adults, recommended immunizations; and 8) For all Insureds 18 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to: a) smoking control; b) nutrition and diet recommendations; c) exercise plans; d) lower back protection; e) weight control; f) immunization practices; g) breast self-examination; h) testicular self-examination; and i) seat belt usage. If a Physician or other health care provider recommends that it would be medically appropriate for an Insured to receive a different schedule of tests and services than those listed above. We will provide payment for the tests actually provided.

Prescription Female Contraceptives - When outpatient prescription drugs are provided as a benefit of the issued Policy, it shall also provide for the purchase of Prescription Female Contraceptives. Prescription Female Contraceptive means any drug or device used for contraception by a female: 1) which is approved by the federal Food and Drug Administration for that purpose; 2) that can only be purchased in the State of New Jersey with a prescription written by a health care professional licensed or authorized to write prescriptions; and 3) includes, but is not limited to, birth control pills and diaphragms.

ACCIDENTAL DEATH & DISMEMBERMENT

$5,000 payable when an injury results in the loss of life within 180 days of the accident. $5,000 payable per Plan schedule for Accidental Dismemberment.

STUDENT MEDICAL EVACUATION

If the Insured requires medical evacuation to his or her natural country as the result of a covered Injury or Sickness, the Company will pay the charges for same not to exceed $10,000. No additional benefits will be paid under the Plan or under any rider providing Major Medical Benefits that might be a part of the Insured's coverage. This benefit will only be payable when: a) the Insured has been Hospital Confined for at least five consecutive days; and b) the medical evacuation has been recommended and approved by the attending physician.

STUDENT REPATRIATION

If the Insured dies while covered under the Plan, the Company will pay the charges not to exceed $7,500 for preparing and transporting the remains of the Insured's body to his or her home country. No additional benefits will be paid under the Plan or under any rider providing Major Medical Benefits that might be a part of the Insured's coverage.

DEFINITIONS

"Accident" means an injury to the body of the Insured caused by physical trauma that results directly from an accident, independently of all other causes; and is not related to the normal functions of the body. Self-inflicted injuries caused by prolonged over-exertion, stress, strain or disease process or aggravation of an existing condition are expressly not covered.

"Benefit Period" means a period of time that begins on the original date of a loss covered by the Policy and continues from that date until the end of the policy term for which premium has been paid. No benefits are payable for any expenses incurred for an Injury or Sickness before or after the Benefit Period.

"Biologically-based Mental Illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the Illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

"Complications of Pregnancy" means: 1) conditions when the pregnancy is not terminated whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. This does NOT include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. 2) nonelective caesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

"Covered Medical Expenses" means reasonable charges that: 1) are made for services and supplies which are a medical necessity; 2) are incurred on the approval of a Physician as a Medical Necessity; 3) do not exceed the Usual and Customary Charge for the service or supply provided; 4) do not exceed the maximum benefit amount payable per service as specified in the Insurance Information Schedule; and 5) are in excess of the Deductible, if any. Charges that do not meet all of these requirements are not covered. Covered Medical Expenses will be deemed incurred only: 1) when the covered services are given; and 2) when a charge is made to the Insured for such service.

"Deductible" means the amount shown in the Insurance Information Schedule or any endorsement as Deductible. It will be subtracted from the amounts payable as Covered Medical Expenses before payment of any benefit is made. The Deductible will apply per term of insurance or per Injury or Sickness as specified in the Insurance Information Schedule.

"Dependent" means the Insured's spouse, a Newborn Infant of the Insured, and Dependent, unmarried children. A child ceases to be a Dependent on the earlier of: 1) the end of the month in which they marry; or 2) the end of the month in which they attain the age 19. A Dependent, unmarried child includes a child placed for the purposes of legal adoption. Coverage for the child will be effective on the date of placement in the physical custody of the adoptive parent. It will continue unless placement is disrupted prior to legal adoption and the child is removed from placement. Coverage for such child will be for Injury or Sickness, including the necessary care and treatment of conditions existing prior to the date of placement. Attaining age 19 will not end the coverage of a child while he is and continues to be both: 1) incapable of self-sustaining employment by reasons of mental or physical handicap; and 2) chiefly Dependent on the Insured for support and maintenance. Proof of such incapacity and dependency must be given to Us by the Insured within 31 days of the child's attaining age 19. After that, proof must be given to Us annually following the child's attaining age 19. If a claim is denied because the child has attained age 19, the burden is on the Insured to establish that the child is and continues to be handicapped as defined in Subsections (1) and (2) of the previous paragraph.

MEDICAL EXPENSE BENEFIT SCHEDULE

Benefits are provided up to $50,000 for Covered Medical Expense incurred, inpatient or outpatient, as the result of a covered accidental injury or sickness. The initial treatment for an accidental injury must be rendered within 60 days of the accident. Benefits for a covered injury or sickness are limited to treatment received during the term of the Policy. The Company will pay for the reasonable and necessary services in accordance with the usual and customary charge normally made for such services.

Inpatient	**For Accidents**	**For Sickness**
Room/Board/ICU	80% U&C up to semi-private room rate	80% U&C up to semi-private room rate
Hospital Misc.	Up to $1,000 per day	Up to $1,000 per day
*Surgery	80% of U&C according to MDR	80% of U&C according to MDR
Anesthetist	25% of Surgical Benefit	25% of Surgical Benefit
Private Duty RN	$50 per day; Max $250	$50 per day; Max $250
Physician's Visits	$100 per day	$100 per day
Physiotherapy	Up to $75 per visit	Up to $75 per visit
Preadmission Testing	Included under "Hospital Misc"	included under "Hospital Misc"
Psychotherapy	NIL	Treated as any other illness
Outpatient		
*Surgery	80% of U&C according to MDR	80% of U&C according to MDR
Day Surgery Misc.	100% up to $500, then 80% to a total Max of $5,000	100% up to $500, then 80% to a total Max of $5,000
Anesthetist	25% of Surgical Benefit	25% of Surgical Benefit
Outpatient Misc.	$2,500	$2,500
**Physician's Visits	$100 per visit beginning with 2nd visit; up to $750 maximum	$100 per visit beginning with 2nd visit; up to $750 maximum
Physiotherapy	$75 per visit beginning with 2nd visit; up to $750 maximum	$75 per visit beginning with 2nd visit; up to $750 maximum
Emergency Room	Included in "Outpatient Misc."	Included in "Outpatient Misc."
X-rays/Lab Tests	Included in "Outpatient Misc."	Included in "Outpatient Misc."
Tests & Procedures	Included in "Outpatient Misc."	Included in "Outpatient Misc."
**Outpatient Psychotherapy (Mental & Nervous)	No Benefit	$100 per visit up to $2,500 max
Other		
Prescription Drugs	Up to $500	Up to $500
Consultant	$150	$150
Dental	Up to $500/accident	Up to $100/tooth for impacted wisdom teeth
Mandated Benefits		
Wellness Testing	No Benefit	Scheduled
Alcoholism Treatment	No Benefit	Treated as any other illness
Reconstructive Breast Surgery	No Benefit	Treated as any other illness
Treatment of Diabetes, Equipment/Supplies/Education	No Benefit	Treated as any other illness
Treatment of Wilm's Tumor	No Benefit	Treated as any other illness
Therapeutic Treatment of inherited Metabolic Diseases	No Benefit	Treated as any other illness
Mammography (age 35+) , Pap Smears & Prostate testing	No Benefit	Included in "Outpatient Misc."
Chemical Dependency & Drug Addiction	No Benefit	Treated as any other illness
Maternity	No Benefit	Treated as any other illness
Childhood Immunizations	No Benefit	Treated as any other illness
Lead Poisoning Screening for Children	No Benefit	Treated as any other illness
Cancer Treatment; Bone Marrow Transplants	No Benefit	Treated as any other illness
Dental Trmt. for Severely Disabled or Children	No Benefit	Treated as any other illness
Home Health Care	U&C up to 60 visits	U&C up to 60 visits
Hemophilia	No Benefit	Treated as any other illness
Infant Formulas	No Benefit	Treated as any other illness
Colorectal Cancer Screening	No Benefit	Treated as any other illness
Audiology and Speech Language Pathology	No Benefit	Treated as any other illness
Biologically Based Mental Illness	No Benefit	Treated as any other illness

*Based on the Medical Data Research (MDR) Schedule for the Usual & Customary.

**If student receives treatment at Student Health Services it will count as 1st visit. If Student Health Services is closed or unavailable, the 1st visit will be paid up to a $50 maximum.

"Elective Surgery or Elective Treatment" includes, but is not limited to, surgery and/or treatment for: acne; acupuncture; allergy, including allergy testing; biofeedback-type services; birth control; breast implants; breast reduction; circumcision; corns, calluses & bunions; deviated nasal septum, including submucous resection and/or other surgical correction of same; family planning; fertility tests; impotence, organic or otherwise; infertility, (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; nonmalignant warts, moles and lesions; obesity and any conditions resulting from same (including hernia or any kind); premarital examinations; preventive medicine or vaccines or diet supplements; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders and testing for same; temporomandibular joint dysfunction; tubal ligation; vasectomy and weight reduction. Elective Surgery or Elective Treatment also includes a service, treatment or supply that we deem to be research or experimental; or is not generally recognized and generally accepted medical practice in the United States.

"Extended Care Benefits" means a facility that: 1) is operated pursuant to law; 2) is approved for payment of Medicare benefits or is qualified to receive such approval, if so requested; 3) is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a licensed Physician; 4) provides continuous 24 hour a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and 5) maintains a daily medical record of each patient.

Extended Care Facility does not mean: 1) any home, facility or part thereof used primarily for rest; 2) a home or facility for the aged or for the care of drug addicts; or 3) a home or facility primarily used for the care and treatment of mental Diseases or disorders, or custodial or educational care.

"Home Health Care" means those nursing and other home health care services rendered to the Insured in his place of residence under the following conditions: 1) on a part-time or intermittent basis, except when full-time or 24-hour services are needed on a short-term basis; 2) if continuing hospitalization would have been required if Home Health Care was not available; 3) pursuant to a physician's order and under a plan of care established by the physician and a home health care provider.

"Hospital" means an institution that: 1) is operated pursuant to law; 2) operates primarily for the reception, care and treatment of sick or injured persons on an inpatient basis for which a charge is made; 3) provides 24-hour nursing service by or under the supervision of Registered Nurses; 4) has a staff of one or more Physicians available

at all times; and 5) provides organized facilities for diagnosis, treatment and surgery, either on its premises or in facilities available to it on a prearranged basis. Hospital does not include: 1) convalescent homes, convalescent, rest or nursing facilities; 2) facilities primarily affording custodial, educational or rehabilitative care; 3) facilities for the aged or drug addicts; 4) an institution specializing in or primarily treating Mental or Nervous Disorders, other than for the treatment of biologically-based mental illness; or 5) any military or veterans' Hospital or soldiers home or any Hospital contracted by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the Insured for such services.

"Hospital Confined" means confined in a hospital for at least 18 hours by reason of an injury or sickness for which benefits are payable.

"Illness, Sickness, or Disease" means sickness or disease that causes loss beginning while the Policy is in force and which is not excluded under a pre-existing condition limitation. All related conditions and recurrent symptoms of the same or a similar condition will be considered one illness.

"Immediate Family Member" means the Insureds' spouse, mother, father, brother or sister or the Insureds' spouses' mother, father, brother or sister.

"Injury" means accidental bodily injury or injuries resulting directly and independently of all other causes sustained while the Policy is in force for the Insured which results in loss covered by the Policy.

"Insured" means: 1) an eligible, registered student of the Policyholder who has properly enrolled in the program and has paid the appropriate premium for his or her coverage; and 2) their Dependents, if: a) the Dependent is properly enrolled in the program; b) the appropriate Dependent premium has been paid.

"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.

"Medical Necessity" means those services or supplies given or prescribed by a hospital or physician which are: 1) essential for the symptoms and diagnosis or treatment of sickness or injury; 2) given for the diagnosis or direct care and treatment of sickness or injury; 3) in accordance with the standards of good medical practice; 4) not primarily for

the convenience of the Insured or his physician; 5) the most appropriate supply or level of service which can safely be given to the Insured.

"Miscellaneous Supplies (Outpatient)" includes, but is not limited to, Ace Bandages, sutures and suturing supplies, Band-Aids, injections, medications, oxygen, blood and blood plasma.

"Per Injury or Per Sickness" means one or more terms of impairment due to the same or related cause. Each term will end only when there is complete recovery from the Injury or Sickness. The Insured's Physician will decide when there is complete recovery.

"Physician" means a practitioner of the healing arts operating within the scope of his or her license. A Physician does not include an Immediate Family Member. A physician includes at least the following 1) a Doctor of Medicine (M.D.); 2) a Doctor of Osteopathy (D.O.); 3) a Doctor of Dentistry (D.M.D. or D.D.S.); 4) a Doctor of Chiropractic (D.C.); 5) a doctor of Optometry (O.D.); 6) a Doctor of Podiatry (D.P.M.); 7) a Doctor of Psychology (Ph.D.); or 8) any other health care practitioner that state law requires us to recognize as a Physician. The term "Physician" does not mean a social worker or sociologist.

"Pre-existing Condition" means an injury or sickness for which the Insured received treatment or advice from a physician or used prescriptions drugs within the six (6) month period immediately preceding the effective date of coverage under the Policy.

"Psychotherapy" means the treatment of a Mental and Nervous Disorder. Psychotherapy must be administered by an M.D. or a licensed psychologist, Ph.D.

"Registered Nurse" means a licensed professional nurse (R.N.). A Nurse does not include an Immediate Family Member.

"Sound, Natural Teeth" means natural teeth, of which the major portion of the individual tooth is present, regardless of fillings or caps and which is not carious, abscessed or defective.

"Usual and Customary Charges" means a reasonable charge that is: (a) usual and customary when compared with charges made for similar services and supplies; and (b) made to persons having similar medical conditions in the locality of the school. No payment will be made under the Policy for any expenses incurred which in the judgement of the Company are in excess of the usual and customary charges.

"Total Disability", in so far as the Extension of Benefits and/or the Continuation of Coverage provisions are concerned, means that the Insured Student is not engaged in any gainful occupation and is completely unable, due to Sickness or Injury or both, to engage in any and every gainful occupation for which the person is reasonably fitted by education, training or experience. Under the terms of the Policy, this would mean that he or she is unable to continue their studies as the result of that Total Disability.

EXCLUSIONS

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

1. Services given normally without charge by the Health Service of the school, or by any person employed or retained by the school or services covered or given by the student health fee;
2. Eye examinations; prescriptions or fitting of eyeglasses and contact lenses; or other treatment for visual defects and problems. "Visual Defects" means any physical defect of the eye which does or can impair normal vision;
3. 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;
4. Dental treatment, except for accidental injury to sound, natural teeth;
5. 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);
6. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
7. Injury sustained requiring medical treatment while: 1) participating in any interscholastic, intercollegiate, club, professional or semi-professional sport, contest or competition; 2) traveling to or from such sport, contest or competition as a participant; or 3) while participating in any practice or conditioning program for such sport, contest or competition, except as may be specifically provided.
8. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
9. Treatment in a Government Hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
10. Elective surgery and elective treatment, as defined in the Policy;

11. Congenital conditions, except as specifically provided for newborn infants;
12. Injury or sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
13. Organ transplants; reimplantation, transplantation or experimental surgery;
14. Cosmetic surgery, unless related to treatment of a covered Accident or for treatment of medically diagnosed congenital defects and birth abnormalities for Dependents covered from the moment of birth;
15. Hospital confinement for purposes of custodial care;
16. Elective abortion; and
17. Treatment and hospitalization of mental disorders, other than Biologically-based Mental Illness, except as specifically provided.

PRE-EXISTING CONDITION LIMITATION

No benefit will be payable under the Policy for the first 12 months following the effective date of the Insured's coverage. However, this provision will not limit benefits for a pre-existing condition if: 1) during the period immediately preceding the Insured's becoming insured under the Policy, he or she was enrolled as a member under another group or individual policy that provided similar benefits with no lapse in coverage; and 2) benefits were paid for the pre-existing condition under the prior group policy.

TERMINATION OF INSURANCE

Benefits are payable under this Plan only for those Covered charges incurred while the Plan is in effect as to the Insured Person. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under the Extension of Benefits provision shown below.

LIMITATIONS

This Plan cannot establish physicians fees, and therefore, cannot guarantee that payments made by the Insurance Company will cover all physician and surgeon charges in full.

No benefit will be payable for in vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection, when the required coverage is contrary to the religious institutions bona fide religious tenets.

EXTENSION OF BENEFITS

In the event that the Insured is totally disabled as the result of a covered Injury or Sickness on the date that his or her coverage is to end as the result of the termination of the Policy, the Benefit Period will be extended for an additional 90 days beyond the date of termination. Any Covered

Medical Expenses incurred during this time will be covered subject to the Policy's regular benefit limits, exclusions and limitations, and any other applicable Policy provision.

The total payments made in respect to the Insured for such condition both before and after the termination date will never exceed the maximum benefit shown in the Insurance Information Schedule. If the Insured is also an Insured under the succeeding Policy issued by the Company to the Policyholder, this provision will not apply.

CLAIMS PROVISIONS

NOTICE OF CLAIM: You must give written notice of claim to us or T.L. Groseclose Associates. This must be done within thirty (30) days after a claim begins or as soon as possible. Notice given by or on your behalf with enough information to identify you is notice to us.

CLAIM FORMS: When we receive a notice of claim, we will furnish claim forms. If we do not do this within 15 days after we get written notice, you can send us written proof of loss telling us of the occurrence, the character and extent of the loss for which claim is made.

PROOF OF LOSS: Written Proof of Loss must be given to us or our authorized agent within 90 days of the loss. If it is not given within the time required, the claim will not be invalid or reduced if it was not reasonably possible to do so.

Proof of loss must describe the incident, extent and the type of loss. For death claims, proof of loss means certified copies of the death certificate, autopsy (if performed), Coroner, Medical Examiner or Justice of the Peace reports. Police Motor Vehicle Accident Report or Police Incident Report, if applicable, are also Proof of Loss documents.

If the claim is for a continuing loss for which we made periodic payments, written proof of loss must be given to us within 90 days after the end of each period that benefits are payable, or as soon as possible.

TIME OF PAYMENT OF CLAIMS: We will pay all benefits due not more than 60 days after receipt of proof of loss.

PAYMENT OF CLAIMS: Benefits for loss of life will be paid to the beneficiary. If no beneficiary has been designated, benefits will be paid to your estate. Any other accrued benefits, not to exceed the principle sum of the Accidental Death and Dismemberment benefit, if applicable, unpaid at your death may, at our option, be paid either to the beneficiary or to your estate. All other benefits will be paid to the Insured. We may pay benefits for Covered Medical Expenses directly to the provider of medical services if you request us to do so. Any such payment by us in good faith will end our liability to the extent of such payment.

BENEFICIARY: Accidental death benefits, if any, will be paid to the beneficiary as designated in writing by you and on file with the Plan Administrator. If no beneficiary has been named, benefits will be payable in the following order of preference: 1) to the spouse, if living; otherwise 2) equally to any lawful children, if living; otherwise 3) equally to the mother and father, if living; otherwise 4) to your estate.

BENEFICIARY DESIGNATION: You may choose one or more beneficiaries. We will give forms for this use. Such forms must be filed with the Plan Administrator. The beneficiary may be changed at any time. The beneficiary's consent is not required unless an irrevocable beneficiary has been named. The change will be effective only upon receipt by the Plan Administrator. The change will take effect on the date it is signed. Any payment we make in good faith before we receive any beneficiary change will end our liability to the extent of such payment.

LEGAL ACTIONS: No legal action can be brought to recover on the Policy prior to the end of 60 days after written proofs of loss have been given. No such action can be brought after 3 years from the time written Proofs of Loss are required to be given.

PHYSICAL EXAMINATION: As a part of Proof of Loss, we, at our own expense, have the right: 1) to examine the person of any Insured when and as often as we may reasonably require while a claim is pending; and 2) to have an autopsy made in case of death where it is not forbidden by law.

We have the right to get a Physician's opinion about treatment or hospitalization. If you do not show up for an exam by a Physician when we request it, we may: 1) withhold payment of Covered Medical Expenses until the exam is done and the Physician's report is received; and 2) deduct from benefits the amount we had to pay the physician who was to make the exam.

Your out-of-pocket costs may be lower when you utilize a Devon provider. For a listing of Devon providers go to: www.devonhealth.com
800-431-2273

CLAIM PROCEDURES

In the event of an Injury or Sickness the Insured Person should:

1. If at Seton Hall University, report to the Student Health Service so that proper treatment can be prescribed or approved, and obtain a claim form (claim forms may be downloaded and printed from the Seton Hall University website); or
2. If away from Seton Hall University, consult a Doctor.
3. Notify the Claims Administrator, T.L. Groseclose Associates, within 30 days after the date of the Injury or commencement of the Sickness, or as soon thereafter as is reasonably possible.
4. Complete the claim form in full.
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 T.L. Groseclose Associates at the address listed on the next panel.
6. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills should be mailed promptly to T.L. Groseclose Associates 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, T. L. Groseclose Associates.

PLEASE RETAIN THIS CARD
THIS IS TO CERTIFY THAT

____
Name of Insured

IS PARTICIPATING IN THE 2008–2009
STUDENT MEDICAL INSURANCE PLAN FOR
SETON HALL UNIVERSITY
Policy# 2008G3A31

Possession of this card does not guarantee eligibility.
The student must be enrolled in the plan.
Eligibility is subject to Verification by Plan Administrator.

HOW TO FILE AN APPEAL

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an insured student who disagrees with how a claim was processed may appeal that decision. The student must request an appeal in writing within 60 days of the date appearing on the EOB. The appeal request must include why they disagree with the way the claim was processed. The request must include any additional information they feel supports their request for appeal, e.g. medical records, physician records, etc. Please submit all appeal requests to T.L. Groseclose Associates, Inc., 190 Tamarack Circle, Skillman, NJ 08558.

Submit all claims to the address indicated below:

T.L. Groseclose Associates, Inc.
190 Tamarack Circle • Skillman, NJ 08558
609-279-1507 • 866-769-3084

Underwritten by
Security Mutual Life Insurance Company of New York
Binghamton, NY

800-431-2273
www.devonhealth.com

Claims Administrator & Servicing Agent:

T.L. Groseclose Associates, Inc.
190 Tamarack Circle • Skillman, NJ 08558
609-279-1507 • 866-769-3084

Network Provider:

Devon Health Services, Inc.
800-431-2273 • www.devonhealth.com

Underwritten By:

Security Mutual Life Insurance Company of New York
Binghamton, NY

as policy form # SMLGP-1000

For a copy of the Company's privacy notice you may:

go to

www.commercialtravelers.com/privacy.html

or

Request one from the Health office at your school

or

Request one from:
Commercial Travelers
Mutual Insurance Company
c/o Privacy Officer
70 Genesee Street
Utica, NY 13502

(Please indicate the school you attend with your written request.)

Representations of this plan must be approved by the Company.

Contents:

Eligibility & Cost
Effective & Termination Dates
Benefits
Medical Evacuation and Repatriation
Definitions
Exclusions & Limitations
Claims Provisions & Procedures

Please keep this certificate as a summary of your insurance. The Insurance Policy is on file at the College and contains all of the provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between the certificate and the Policy, the Policy will govern and control the payment of benefits.

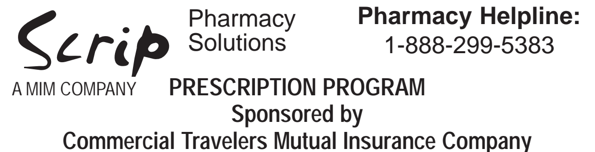
Note: The time you were covered under this plan may count as creditable coverage under State and Federal Law if you leave this plan and go to an employer's plan within 63 days thereafter. You are eligible to receive a certification from the Company regarding the periods you were covered. Please contact the Agent, T.L. Groseclose Associates when you need such certification.

PRESCRIPTION DRUG DISCOUNT CARD

Your student insurance plan includes a prescription drug discount card which may reduce your out-of-pocket costs for prescriptions filled at a participating Scrip Pharmacy Solutions pharmacy. This card offers a discount on covered prescriptions as well as those that are not eligible for coverage under your Student Insurance Plan. You may file a claim for benefits for covered prescriptions following the claims procedures in the Claim Procedure section of this brochure.

The prescription benefit ID card is on the last page of this brochure. Cut it out and carry it with you and present it whenever you or one of your eligible dependents fill a prescription from a participating pharmacy in order to receive your discount. Some participating pharmacies include: Wal-mart, Walgreens, Phar-Mor, Target, Safeway, Winn-Dixie, Drug Emporium, K-Mart, Rite-Aid, Kroger, Publix, Sam's Club, Giant Foods and Eckerd.

Information about additional network pharmacy locations may be requested by calling Scrip Pharmacy Solutions Pharmacy Helpline toll-free at 1-888-299-5383. Pharmacists are on call, in case of emergency, 24 hours a day, 7 days a week.



Pharmacy Helpline:
1-888-299-5383

PRESCRIPTION PROGRAM
Sponsored by
Commercial Travelers Mutual Insurance Company

Social Security Number: ______________________

Name: ______________________

Date of Birth: ______________________

RxBIN: 900020 **RxPCN: CLAIMNE** **RxGrp: CTMIC**

MEDEX ASSISTANCE SERVICES

MEDEX assures the proper coordination and monitoring of medical care. Their services include:

- Assistance in locating the nearest, most appropriate medical care
- Evaluation and monitoring of treatment
- Management of medically necessary evacuations and repatriation of mortal remains
- Blood, vaccine and medication transfers worldwide
- Maintaining contact with family members, personal physicians and employers
- Translation services
- Verification of insurance coverage to facilitate hospital admission
- Coordination of direct payments to providers
- Emergency international transfer of funds
- Legal referral assistance
- Special assistance in replacing lost or stolen travel documents

A toll-free or collect call immediately links you to MEDEX's highly trained, multilingual assistance coordinators, 24 hours a day, every day of the year, call:

1-800-527-0218
Program No. 570

Notice to Cardholders

Please carry this benefit card and present it whenever you or one of your eligible dependents requires a prescription from a participating pharmacy. For information about coverage or network pharmacy locations, please call our Subscriber Helpline at 1-888-299-5383.

Notice to Pharmacies

Covered prescriptions may be filled at any of our 46,000 Scrip Pharmacy Solutions participating pharmacies. For information regarding claims transmission, or becoming a participating pharmacy, please call our Pharmacy Helpline at 1-888-299-5383.