



Student Accident and Sickness Insurance Plan

designed for

Daemen College 2009-2010

– Non Renewable One Year Term Insurance –

Policy Number: USO10023
Amherst, New York

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Student Accident and Sickness Insurance Plan

This is a brief description of the Student Accident and Sickness Insurance Plan available for Daemen College students. The plan is underwritten by United States Fire Insurance Company and is managed by Gallagher Koster. Claims are paid by Klais and Company, Inc. The exact provisions governing this insurance are contained in the Master Policy issued to the College; the Policy may be viewed during normal business hours at the Student Health & Insurance Services Office. The Master Policy will control in the event of any conflict with this brochure.

Eligibility

All students living on campus, all international students, all student athletes, and all students in health related fields of study who will be participating in clinical internships/clerkships are required to be covered by health insurance. These students must either enroll in the College plan or sign a waiver indicating they have other comparable insurance coverage that can be used in the United States. The waiver form can be completed in person in the Health & Insurance Services Office on campus or by going on line to www.gallagherkoster.com. Students who waive on line will select Daemen College, create a user ID and password and complete the waiver form. Make sure you have your student account holder number (which can be found on your tuition bill) and your current health insurance information available when you go online to complete the waiver. All other Daemen College students may enroll on the plan on a voluntary basis through www.gallagherkoster.com.

To document proof of comparable coverage a waiver form must be completed and submitted by the deadline.

1. Go to www.gallagherkoster.com.
2. Click on "College and University Students".
3. Select "Daemen College" from the dropdown menu.
First Time Users will need to create a unique User Account (User Name and Password, first name, last name, student ID number, date of birth and email address). Returning students can log in with their existing User Account information.
4. After creating or accessing your User Account, click on "Student Waive/Enroll Forms" and then select "Daemen College 2009 - 2010 Decision Form".

To complete the waiver section of the Decision Form. You will need to provide information from your current health insurance card: name, claims address, and toll-free customer service number of the insurance carrier, the name of the policyholder and policyholder ID or group number.

Immediately upon submitting the Decision Form, you will receive a confirmation number indicating that the form has been successfully submitted. Print this confirmation number for your records. If you do not receive a confirmation number, you will need to correct any errors and resubmit the form. The online process is the only accepted process for waiving or enrolling in coverage.

Daemen College reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Daemen College Student Accident and Sickness Insurance Plan, effective the date that the determination was made and there will be no pro-rata of premium.

In the event students waive the Student Medical Insurance Plan coverage and then lose current coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within

31 days of the qualifying event, there will be no break in coverage. For petitions received after the 31 days, the effective date of coverage will be the date that the petition is received by Gallagher Koster. If approved, the premium will not be prorated.

Waiver Deadline

The deadline for students to complete the Online Decision Form for annual coverage is September 29, 2009 to waive, or October 19, 2009 to enroll. For students newly enrolled for the Spring Semester, the deadline to complete the online Decision form is February 15, 2010 to waive, or March 10, 2010 to enroll. Students who waive the Daemen College Student Accident and Sickness Insurance Plan in the fall waive coverage for the entire policy year. **Students who do not submit the Online Waiver Form by the deadline will be enrolled in and billed for the Daemen College Student Accident and Sickness Insurance Plan.**

Dependent Eligibility and Enrollment

Eligible dependents of students enrolled in the Plan may participate on a voluntary basis. Dependents must be enrolled at the time of the Participant's enrollment or within 31 days of birth of a newborn. Eligible dependents are the spouse and unmarried children under 19 years of age (or 25 if a full-time student) and who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student.

It is the student's responsibility to enroll eligible dependents by the deadline each year. Dependents are not automatically re-enrolled. Previously enrolled dependents must be re-enrolled for coverage by September 21, 2009, in order to avoid a break in coverage.

1. The Effective Date for an Insured's eligible spouse or dependents enrolled with an Insured is the Insured's Effective Date provided we receive the required premium for the spouse or dependent by the enrollment deadline. If a spouse or dependent becomes eligible after an Insured's Effective Date, the Insured has at least 30 days from the date such spouse or dependent first becomes eligible to enroll them and pay the applicable premium.
2. Automatic Coverage for Newly Acquired Dependents. A newborn child, of an Insured, will be automatically covered for the first 31 days after birth. An adopted child or child placed with an Insured in anticipation of adoption will be automatically covered for 31 days from the date of placement. The automatic coverage of a newborn child or child placed for adoption will end on the 32nd day after birth or placement. Coverage for such a child will be the same as any other dependent, including medically diagnosed congenital defects, birth abnormalities, premature birth care and nursery care.

An 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 date of birth, adoption, or placement for adoption: a) Enroll such dependent; and b) 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 first 31 days after the child's birth, adoption, or placement for adoption.

To enroll a dependent, the student can go to www.gallagherkoster.com, select the Daemen College page and complete the dependent enrollment form.

Effective and Termination Dates

The Master Policy becomes effective at 12:01 a.m. August 20, 2009 and terminates on August 19, 2010 for annual term coverage and becomes effective at 12:01 a.m. on January 27, 2010 and terminates

on August 19, 2010 for Spring/Summer term coverage. This 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. Insured persons, who have not received information regarding a subsequent plan prior to the Policy's termination Date, should inquire regarding such coverage with the school or its agent.

Plan Costs and Period of Coverage

	Annual Enrollment 08/20/09 to 08/19/10	Fall Enrollment 08/20/09 to 01/26/10	Spring Enrollment 01/27/10 to 08/19/10
Student Only	\$1,150.00	\$493.00	\$ 678.00
Spouse Only	\$1,834.00	\$779.00	\$1,075.00
Per Child	\$1,834.00	\$779.00	\$1,075.00

Coverage Ends: An Insured's coverage ends on the earliest of the following: 1) The date the Insured ceases to be eligible for coverage; or 2) The end of the Insured's term of coverage. An Insured's spouse or dependent coverage will end at the earliest of: 1) The end of the period for which the premium is paid for such spouse or dependent coverage; 2) The date a spouse or dependent is no longer eligible for coverage; or 3) The end of the Insured's term of coverage.

What is the relationship between Daemen College and Family Care Medical Center?

Daemen College contracts with Family Care Medical Center during the academic year to provide health care services to students of the College who are enrolled in the Accident and Sickness Insurance Plan.

Family Care Medical Center

61 Maple Road
Williamsville, NY 14221
(716) 565-1234

Mon - Thurs 7:30 am - 5 pm

Fri 8 am - Noon

Sat 8 am - 11am

(no appointment needed on Sat.)

Definitions

Accident means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

Coinsurance means the percentage amount of Covered Expenses for which the Covered Person is responsible for any medical service or supply. We will pay the remaining amount of Covered Expenses, subject to the maximum amount for specific services and the maximum benefit for all services.

Complications of pregnancy means: a) Conditions whose diagnosis is distinct from but adversely affected or caused by pregnancy and which require a hospital stay (when pregnancy is not terminated). Such conditions include, but are not limited to, acute nephritis; nephrosis; cardiac de-compensation; missed abortion; hyperemesis gravidarum; pre-eclampsia; and similar conditions of comparable severity; or b) Non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; and spontaneous termination of a pregnancy during a period of gestation when a viable birth is not possible. Complications of pregnancy do not include: False labor; Occasional spotting; Doctor-prescribed rest during pregnancy; Morning

sickness; or Similar conditions associated with a difficult pregnancy that are not classified as a complication of pregnancy.

Co-payment means that portion of eligible Expenses which is payable by the Insured. Co-payments do not apply toward the Deductible and coinsurance obligations.

Covered expenses means charges: a) Not in excess of usual, reasonable and customary charge; b) Not in excess of the maximum benefit amount payable per service; c) Made for medical services and supplies not excluded under the policy; d) Made for services and supplies which are **medically necessary**; and e) Made for medical services specifically included in the Policy.

Covered Person means the covered student and his eligible Dependents, if dependents coverage is available and the covered student has applied for such dependent's coverage and paid the required premium.

Deductible means the amount of Covered Expenses paid by the Covered Person before benefits are payable under the policy.

Dependent means a covered student's unmarried child who: a) Chiefly relies on him or her for support and maintenance; and b) Is within the following age groups unless otherwise stated in the policy (1) Under 19 years of age; (2) 19 but less than 25 years of age and enrolled in a School as a full-time student; or (3) 19 or more years of age, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a Dependent under (1) or (2) above. We may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.

Child includes stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child. Dependent also includes the covered student's lawful spouse.

Doctor means a licensed practitioner of the healing arts acting within the scope of his license. Furthermore, Doctor includes any healthcare practitioner required under New York State law providing a service covered under the policy. Doctor does not include: a) The Covered Person; b) The Covered Person's spouse, dependent, parent, brother, or sister; or c) A person who ordinarily resides with the Covered Person.

Hospital means a short-term, acute, general Hospital which: a) Is duly licensed by the agency responsible for licensing such Hospitals; b) Is primarily engaged in providing, by or under the continuous supervision of Doctors, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons; c) Has organized department of medicine and major surgery; d) Has a requirement that every patient must be under the care of a Doctor or dentist; e) Provides 24-hour nursing service by or under the supervision of a registered professional Nurse (R.N.); f) If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861 (k) of United States Public Law 89-97 (42 USCA 1395X(k)); and is not, other than incidentally; g) A place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care; or h) A military or veterans Hospital or a Hospital contracted for or operated by a national government or its agency unless: (1) The services are rendered on an emergency basis; and (2) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided and a per diem charge is made by the Hospital.

Injury means bodily harm resulting, directly and independently of disease or bodily infirmity, from an accident. All Injuries to the same person sustained in one accident, including all related conditions and recurring symptoms of Injuries will be considered one Injury.

Medical Emergency means the occurrence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in: a) Placing one's health (for a pregnant woman this includes the health of the newborn) in serious jeopardy; b) Serious impairment to bodily functions; c) Serious dysfunction of any body organ or part; or d) Serious disfigurement of such person. Expenses incurred for Medical Emergency will be paid only for an Injury or Sickness fulfilling the above conditions. These expenses will not be paid for minor Injuries.

Medically Necessary means those services or supplies provided or prescribed by a Hospital or Doctor: a) Essential for the symptoms and diagnosis or treatment of the Injury or Sickness; b) Provided for the diagnosis, or the direct care and treatment of the Injury or Sickness; c) In accordance with the standards of good medical practice; d) Not primarily for the Covered Person's convenience or for that of the Covered Person's Doctor; and, e) That are the most appropriate supply or level of service that can safely be provided.

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

Nurse means either a professional, licensed, graduate registered Nurse (R.N.) or a professional, licensed practical Nurse (L.P.N.). Nurse also includes a midwife who is certified as such by the American College of Nurse Midwives and licensed as a Registered Nurse (RN).

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 Doctor.

Pre-Existing Condition means any Injury or Sickness or condition manifesting in symptoms during the 6 months immediately preceding the effective date of a Covered Person's insurance under the Policy or to a pregnancy existing on the effective date of such Covered Person's coverage. If the Covered Person has had continuous coverage under this or a similar Health Insurance Plan from one year to the next, an Injury or Sickness that first manifests itself during a prior year's coverage shall not be considered a Pre-Existing Condition.

Prescription means any authorization, including authorized refills, issued by a Doctor for dispensing medication for the purpose and in the amount specified.

Sickness means illness, disease, normal pregnancy for the Insured Student, and Complications of Pregnancy that first manifests itself after the effective date of a Covered Person's coverage under the policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Usual, Reasonable and Customary means: a) Charges and fees for medical services or supplies that are the lesser of: (1) The usual charge by the provider for the service or supply given; or (2) The average charged for the service or supply in the area where service or supply is received; and b) Treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition.

Basic Accident Medical Expense Benefit

If as a result of an Injury, occurring during the term Insured, a Covered Person incurs covered medical Expenses, We will pay, after a \$50.00 deductible, the Usual, Reasonable and Customary Expense incurred up to a maximum of \$1,000 per Injury. The Deductible will be waived

if the Insured utilizes Family Care Medical Center and/or MedFirst or when referred by Family Care or the Health & Insurance Services Office. Covered medical expenses are those expenses for physicians, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other Usual, Reasonable and Customary Expense incurred while insured under the Policy. Injuries to natural teeth are covered on the same basis as any other injury. Also refer to the section on the Supplemental Accident and Sickness Insurance Benefit.

Basic Sickness Medical Expense Benefit

If as the result of Sickness, a Covered Person incurs covered medical Expenses, We will pay, after a \$50 deductible, following Covered Expenses as allocated below, up to a maximum of \$1,000 per Sickness. The Deductible will be waived if the Insured utilizes Family Care Medical Center and/or MedFirst or when referred by Family Care or the Health & Insurance Services Office. Maternity Expense and complications of pregnancy, conception occurring during the term insured will be covered on the same basis as any other sickness. Also refer to the section on the Supplemental Accident and Sickness Insurance Benefit.

Inpatient Expense

Hospital Room and Board Expense: If a Covered Person requires confinement in a hospital, We will pay the semi-private room rate up to \$225 per day for Hospitalization and \$500 per day for ICU when medically necessary and ordered by the attending physician.

Miscellaneous Hospital Expense: If a Covered Person incurs Expenses during a hospital confinement or day surgery on an outpatient basis for: a) anesthesia, anesthesia supplies and services; b) operating room and equipment; c) diagnostic x-ray and laboratory tests; d) lab studies; e) prescribed drugs and medicines; (f) radiation and chemotherapy; and g) other necessary and prescribed hospital expenses, We will pay the Covered Charges incurred, up to a maximum of \$500 per Sickness.

Pre-Admission Test Expense: If a Covered Person requires outpatient testing, that was ordered by a physician, prior to admission as an inpatient, We will pay the Expense incurred up to \$500 per Sickness.

Surgeon Expense (Inpatient or Outpatient): If a Covered Person requires surgery, We will pay the Usual, Reasonable, and Customary Expense incurred, up to a maximum of \$1,000 per Sickness.

Anesthetist Expense: If a Covered person incurs Expenses during surgery for an Anesthetist, We will pay up to 25% of the amount payable under the Surgeon Expense.

Assistant Surgeon Expense: If a Covered person incurs Expenses during surgery for an Assistant Surgeon, We will pay up to 25% of the amount payable under the Surgeon Expense.

In-Hospital Doctor's Visit: If a Covered Person who is confined as a resident bed-patient in a hospital, requires the services of a Doctor We will pay the Usual, Reasonable and Customary Expense incurred, limited to one visit per day, up to \$50.00 per visit per Sickness. The physician may not be the Surgeon who operated on you.

Inpatient Mental and Emotional Disorders: We will pay the Usual, Reasonable and Customary Expense incurred for Inpatient Mental and Emotional disorder treatment, up to 30 days per condition

Inpatient Nurse Expense: If a Covered person incurs Expenses provided by a nurse, during Hospital confinement, We will pay the Usual, Reasonable and Customary Expenses not to exceed \$50 per day during any one 24 hour period, up to 10 days. Services of a licensed registered, or practical nurse must be: 1) authorized by the attending Physician; and 2) provided by a nurse who is not a regular staff member for the Hospital in which an Insured Person is confined.

Outpatient Expense

Doctor's Office Visit: If a Covered Person who is not hospital-confined, requires the services of a Doctor We will pay the Usual, Reasonable and Customary Expense incurred up to \$75 for the first visit and \$60 each subsequent visit, not to exceed 10 visits per Sickness. The physician may not be the surgeon who operated on you. A \$10 per visit deductible will apply.

Consultant/Specialist Expense (Inpatient or Outpatient): If by reason of Injury or Sickness, a Covered Person requires the services of a Consultant or Specialist when they are deemed necessary and ordered by an attending Doctor, or the Health & Insurance Services Office for the purpose of confirming or determining a diagnosis, We will pay the Usual, Reasonable and Customary Expense incurred up to a maximum of \$100 per Sickness.

Ambulance Expense: If a Covered Person requires the use of an ambulance due to a medical emergency, We will pay the Usual, Reasonable and Customary Expense incurred, up to a maximum of \$200 per Sickness.

Hospital Outpatient Miscellaneous Expense: If a Covered Person requires the use of outpatient x-ray, laboratory tests, or the use of an emergency or operating room, We will pay the Usual, Reasonable and Customary Expense incurred, up to \$500 per Sickness.

Emergency Medical Expense: We will pay the Usual, Reasonable and Customary Expense incurred for emergency medical services provided by a Hospital not to exceed \$1,000 per sickness. Such emergency services must be provided within 24 hours after the appearance of symptoms of a Sickness. No Expenses will be paid for such charges, if they are payable under any other provision. There is a co-payment of \$50 for Emergency Room care (waived if admitted through the Emergency Room).

Outpatient Diagnostic X-Ray and Laboratory: We will pay the Usual, Reasonable and Customary Expense, not to exceed \$750 for outpatient diagnostic X-rays and laboratory expenses when they have been ordered by the Attending Physician or referred by Family Care Medical Center and/or MedFirst.

Outpatient Prescription Drug Expense: If a Covered Person requires outpatient prescription drugs prescribed by a Doctor, We will pay up to a maximum of \$250 per Sickness for prescribed drugs and medicines per semester, subject to a \$10 co-payment.

Sickness Dental Expense: We will pay the Usual, Reasonable and Customary Expense incurred, up to \$50 per tooth on an inpatient basis and \$25 per tooth on an outpatient basis, for the treatment of impacted wisdom teeth and dental abscesses. No other Policy benefits are payable.

Wellness Benefit: We will pay the Usual, Reasonable and Customary Expenses incurred at 80% up to \$200 per policy year. Coverage includes vaccines (including HPV) and routine doctor visits.

Mental and Nervous Disorders Coverage

Mental, Nervous, or Emotional Disorder Benefit: Benefits will be payable for Active Treatment of mental, nervous, eating disorders, or emotional disorders as follows.

Benefits are payable for inpatient hospital care for 30 days of active treatment per policy year in a hospital defined by Section 1.03(10) of the Mental Hygiene Law and 20 visits of active treatment per policy year for outpatient care in a facility issued an operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a psychiatrist or psychologist, or a professional corporation or university faculty practice corporation.

Benefits are payable the same as any other Sickness for inpatient hospital treatment for adults and children with biologically based mental illness, eating disorders and children with serious emotional disturbances.

Partial hospitalization days shall be covered with two partial hospitalization days equal to one covered inpatient day.

Definitions:

Active treatment means treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the commissioner of mental health. **Active treatment for outpatient visits for biologically based mental illness or children with serious emotional disturbances will not require inpatient confinement to be eligible for outpatient treatment.**

Biologically based mental illness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Under the law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

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

"Eating Disorder" means conditions such as anorexia nervosa, bulimia and binge eating disorder, identified as such in the ICD-9-CM International Classification of Disease or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, or other medical and mental health diagnostic references generally accepted for standard use by the medical and mental health fields.

"Comprehensive care centers for eating disorders" or "comprehensive care centers" means a provider-sponsored system of care, organized by either corporate affiliation or clinical association for the common purpose of providing a coordinated, individualized plan of care for an individual with an eating disorder that includes all necessary non-institutional, institutional and practitioner services and treatments, from initial patient screening and evaluation, to treatment, follow-up care and support.

Exceptions to Coverage

Benefits do not apply to:

1. individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the Office of Children and Family Services;
2. services solely because such services are ordered by a court; or
3. services determined to be cosmetic on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

Benefits provided will be subject to the same deductibles and coinsurance as any other Sickness. Benefits will be subject to the same network limitations, if any, as applicable to the other benefits provided under the Policy.

Chemical Abuse and Treatment

We will cover expenses incurred by a Covered Person for the diagnosis and treatment of **chemical abuse and chemical dependence** as follows: 1) For **detoxification** as a consequence of chemical dependence, we will pay **inpatient benefits** in a hospital or a

detoxification facility for up to 7 days of active treatment in a calendar year. 2) For **rehabilitation services**, we will pay for up to 30 days of inpatient care in any calendar year. Chemical abuse and chemical dependence will be paid in the same manner as those paid for any other illness.

Treatment must be provided in a facility in New York State that are certified by the Office of Alcoholism and Substance Abuse Services and, in other states, to those that are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse or chemical dependence treatment programs.

Chemical Abuse means the abuse of or addiction to alcohol, drugs, or chemicals.

Supplemental Accident and Sickness Medical Expense Benefit

Payment will be made for 80% of the Usual, Customary and Reasonable covered medical expenses for any one injury or sickness, in excess of the \$1,000 paid, under the Basic Accident or Basic Sickness benefit, up to a maximum benefit of an additional \$24,000 payable under this benefit for any one injury or sickness. Covered medical expenses are charges for: physicians, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, plaster casts, surgical dressings, use of ambulances and other medically necessary, reasonable and customary expenses incurred while insured under the Policy. The aggregate maximum will be \$50,000 for all J1 Visa students. All other students will maintain a \$25,000 plan maximum.

Additional Benefits

Bone Mineral Density Measurements and Tests Expense Benefit:

We will pay the Covered Percentage of the Covered Charges incurred for Bone Mineral Density Measurements or Tests for the prevention, diagnosis, and treatment of osteoporosis when requested by a health care provider for a Qualified Individual. A Qualified Individual means an Insured Person who meets the following criteria: (1) previously diagnosed as having osteoporosis or having a family history of osteoporosis; (2) symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; (3) on a prescribed drug regimen posing a significant risk of osteoporosis; (4) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; and (5) with age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis. Coverage includes bone mineral density measurements or tests as covered under the Federal Medicare program as well as those in accordance with the criteria of the National Institute of Health, including dual-energy x-ray absorptiometry. If this Policy includes coverage for outpatient prescription drugs, then We also will cover drugs and devices for bone mineral density that have been approved by the United States Food and Drug Administration or generic equivalents as approved substitutes in accordance with the above criteria. We cover such charges the same way We treat Covered Charges for any other Sickness.

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

will be in the manner determined by the attending Physician and the patient to be appropriate; 3) We will pay the expenses incurred for prostheses and the treatment of physical complications for all stages of a mastectomy, including lymphedemas.

Cancer-Second Opinion Expense Benefit: We cover charges for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. A second medical opinion provided by a non-participating specialist absent a written referral will be covered subject to the payment of additional coinsurance. We treat such charges the same way We treat Covered Charges for any other Sickness.

Chiropractic Care Expense Benefit: We will pay for an Insured Person's Covered Charges for non-surgical treatment to remove nerve interference and its effects, which is caused by or related to Body Distortion. Body Distortion means structural imbalance, distortion or incomplete or partial dislocation in the human body which: (a) is due to or related to distortion, misalignment or incomplete or partial dislocation of or in the vertebral column; and (b) interferes with the human nerves. We treat such charges the same way We treat Covered Charges for any other Sickness.

Cytological Screening Expense Benefit: We cover charges for Expenses incurred for an annual Cytological Screening (Pap smear) for cervical cancer for women eighteen and older. We cover such charges the same way We treat Covered Charges for any other Sickness. Cytologic Screening means collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

Covered Services include charges by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility. We cover such charges the same way We treat Covered Charges for any other Sickness.

Diabetes Treatment Expense Benefit: We cover charges for the following Medically Necessary diabetes equipment and supplies for the treatment of diabetes when recommended by a Doctor or other licensed health care provider. We treat such charges the same way We treat Covered Charges for any other Sickness. Such supplies include: blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar. We also cover charges for expenses incurred for diabetes self-management education. Coverage for self-management education and education relating to diet shall be limited to medically necessary visits upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Insured Person's symptoms or conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Doctor or other licensed healthcare provider; the Doctor's office staff, as part of an office visit; or by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

Diagnostic Screening for Prostatic Cancer Expense Benefit: We cover charges for Diagnostic Screening for Prostatic Cancer as follows: (a) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and (b) an annual standard diagnostic examination including, but not limited to, a digital

rectal examination prostate-specific antigen test for men: 1) age fifty and over who are asymptomatic; and 2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors. We treat such charges the same way We treat Covered Charges for any other Sickness.

End of Life Care Expense Benefit: If an Insured Person is diagnosed with Advanced Cancer, We will cover services provided by a facility or program specializing in the treatment of terminally ill patients if the Insured Person's attending health care practitioner, in consultation with the medical director of the facility or program determines that the Insured Person's care would appropriately be provided by such a facility or program. If We disagree with the admission of the Insured Person into the facility, or the provision or continuation of care by the facility, We will initiate an expedited external appeal. Until a decision is rendered, We will continue to provide coverage for care provided in the facility. The decision of the external appeal agent will be binding on both Us and the Insured Person. Advanced Cancer means a diagnosis of cancer by the Insured Person's attending health care practitioner certifying that there is no hope of reversal of primary disease and that the person has fewer than sixty days to live. We cover such charges the same way We treat Covered Charges for any other Sickness.

Enteral Formulas Expense Benefit: We will pay for an Insured Person's Covered Charges for enteral formulas when prescribed by a Doctor or licensed health care provider. The prescribing Doctor or health care provider must issue a written order stating that the enteral formula is medically necessary and has been proven as a disease-specific treatment for those individuals who are or will become malnourished or suffer from disorders, which if left untreated will cause chronic physical disability, mental retardation or death. We cover enteral formulas and food products required for persons with inherited diseases of amino acid and organic acid metabolism, Crohn's Disease, gastroesophageal reflux with failure to thrive, disorders of the gastrointestinal motility such a chronic intestinal pseudo-obstruction and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. We also cover modified solid food products that are low protein or which contain medically necessary modified protein in an amount not to exceed \$2,500 per calendar year or for any continuous period of twelve months. We treat such charges the same way We treat Covered Charges for any other Sickness.

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

Home Health Care: If, as the result of a covered Injury or Sickness, an Insured Person requires any of the home health care services, as defined, We will pay the reasonable charges incurred for such services. Expenses for such services must be incurred within 156 weeks from the date of the Injury or the start of a covered Sickness. The maximum number of home health care visits is limited to 40 in any period of 12 consecutive months. The amount of this benefit is 100% of the reasonable charges for the above services made by a Home Health Care Agency, minus a deductible of \$50 per year. This benefit does not cover: 1) services furnished outside the State of New York unless they are rendered by an entity licensed to provide Home Health Care in the state where the services were rendered; 2) persons who are not residents of the State of New York; 3) persons who are eligible for Medicare due to age; 4) services which are not part of a Home Health Care plan; 5) services provided by an immediate family member of an Insured Person or a member of an Insured Person's household;

6) custodial care or transportation; or 7) any period during which an Insured Person was not under the care of a Physician.

Maternity Expense Benefit: We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care. We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated caesarean section for an Insured Person and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital. We will cover charges for one home care visit if the mother is discharged earlier than the time periods provided above. The visit must be requested within 48 hours of the delivery (96 hours in the case of a caesarean section) and the services must be delivered within 24 hours: (a) after discharge; or (b) of the time of the mother's request, whichever is later. Charges for the home care visit are not subject to any Deductible, Coinsurance or Co-payments. Covered Charges include at least two payments, at reasonable intervals, for prenatal care and one payment for the delivery and postnatal care provided. We also cover charges for parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.

Newborn Infant Care Expense Benefit: Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth for up to 48 hours for vaginal delivery or 96 hours for cesarean section deliver. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

Inpatient Chemical Abuse and Chemical Dependence Expense Benefit: If on account of Chemical Abuse or Chemical Dependence, an Insured Person requires inpatient treatment, We will pay for such treatment as follows: a) when the Insured Person is confined as an inpatient in a Hospital or a Detoxification Facility, We will pay benefits for detoxification on the same basis as any other Sickness. But, We will not cover more than seven (7) days of active treatment in any one calendar year; b) when the Insured Person is confined in a Hospital or Chemical Abuse Treatment Facility, We will pay benefits for rehabilitation services on the same basis as any other Sickness. But, We will not cover more than thirty (30) days of inpatient care for such services in any one calendar year.

As used in this provision, the term "Chemical Abuse Treatment Facility" means a facility: a) in New York State, which is certified by the Office of Alcoholism and Substance Abuse Services; or b) in other states, which is accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse, or chemical dependence treatment programs.

Outpatient Chemical Abuse and Chemical Dependence Expense Benefit: If on account of Chemical Abuse or Chemical Dependence an Insured Person is not so hospital confined as an inpatient, We will pay the Covered Percentage of Covered Charges incurred for covered outpatient services for the treatment of Alcohol, Substance Abuse or Chemical Dependence. We will pay for up to 60 visits during any one calendar year, for the diagnosis and treatment of Chemical Abuse or Chemical Dependence. Coverage will be limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services as outpatient clinics or medically supervised ambulatory substance programs. In other states, coverage is limited to those facilities which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse, or chemical dependence treatment programs. Outpatient Services consisting of consultant or treatment sessions will not be

payable unless these services are furnished by a Doctor or Psychotherapist who: a) is licensed by the state or territory where the person practices; and b) devotes a substantial part of his or her time treating intoxicated persons, substance abusers, alcohol abusers, or alcoholics. Outpatient coverage includes up to 20 outpatient visits during any one calendar year, for covered family members, even if the Insured Person in need of treatment has not received, or is not receiving treatment for Chemical Abuse or Chemical Dependence provided that the total number of such visits, when combined with those of the Insured Person in need of treatment, do not exceed 60 outpatient visits in any one calendar year, and provided further that the 60 visits shall be reduced only by the number of visits actually utilized by the covered family members. We treat such charges the same way We treat any other Covered Charges for a Sickness.

Mammography Examination Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred for a Mammographic exam. The charges must be incurred while the Insured Person is insured for these benefits. Benefits will be paid for the following: a) one Mammogram at any age for an Insured Person who has a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer, upon recommendation of a Doctor; b) one baseline Mammogram for an Insured Person age thirty-five through thirty-nine; and c) one Mammogram annually for an Insured Person age forty years or older. We cover such charges the same way We treat Covered Charges for any other Sickness.

Pre-hospital Emergency Medical Services Expense Benefit: When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay benefits for the Covered Percentage of the Covered Charges incurred in excess of the deductible shown in the Plan of Insurance. Covered Charges include Pre-Hospital Medical Emergency Services provided by a licensed ambulance service.

As used in this provision, Pre-Hospital Medical Emergency Services means the prompt evaluation and treatment of an emergency medical condition, and/or non-air borne transportation of the patient to a hospital. Where the patient utilizes non-air borne emergency transportation, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; b) serious impairment to such person's bodily functions; c) serious dysfunction of any bodily organ or part of such person; or d) serious disfigurement of such person. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition.

If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

Reconstructive Breast Surgery Expense Benefit: We cover charges for inpatient hospital care for an Insured Person undergoing: a) a lumpectomy or a lymph node dissection for the treatment of breast cancer; or b) a mastectomy which is covered under this Plan. Coverage is limited to a time frame determined by the Insured Person's Doctor to be medically appropriate.

We also cover charges for breast reconstruction surgery after a mastectomy including: a) all stages of reconstruction of the breast on which the mastectomy has been performed; and b) surgery

and reconstruction of the other breast to produce symmetry. Surgery and reconstruction will be provided in a manner determined by the attending Doctor and the Insured Person to be appropriate. We treat such charge the same way We treat any other Covered Charges for a Sickness.

Early Intervention Services Benefit: Benefits will be payable for Early Intervention Services for children up to three years of age who are disabled or at risk of disability on the same basis as any other Sickness. Benefits paid for Early Intervention will not decrease benefits payable for other conditions

Autism Spectrum Disorder Benefit: Benefits will be payable for an Insured Person's Covered Charges on the same basis as any other Sickness for treatment of Autism Spectrum Disorder. "Autism Spectrum Disorder" means a neurobiological condition that includes autism, Asperger syndrome, Rett's syndrome, or pervasive developmental disorder.

Accidental Death, Dismemberment or Loss of Sight Benefit

If a Covered Person incurs an injury which results in any one of the losses listed below, the Company will pay the applicable benefit. The loss must occur within 365 days of the injury. Only one benefit will be paid for loss. If more than one loss occurs due to the same injury, the largest amount for any one of the losses will be paid. Benefits payable under this provision are in addition to any other benefits otherwise payable under this Policy.

For Loss of:	Benefits:
Life	\$5,000
Both Hands, Both Feet, or Sight of Both Eyes	\$5,000
One Hand and One Foot	\$5,000
One Hand and the Sight of One Eye	\$5,000
One Foot and the Sight of One Eye	\$5,000
One Hand or One Foot or Sight of One Eye	\$2,500

Principle Sum: \$5,000. The Principal Sum is the largest amount payable under this benefit for all losses resulting from any one accident.

Termination Of Insurance

Benefits are payable under the Policy only for that covered expense incurred while the Policy is in effect as to the Insured. No benefits are payable for expense incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

Exclusions and Limitations

No benefits will be paid for loss or expense caused by or resulting from:

1. Pre-existing Conditions during the first 12 months of continuous coverage. However, this provision will not limit benefits for a Pre-existing Condition if, during the 63 day period immediately preceding the Insured's becoming insured under the Policy, he or she was enrolled as a member under another policy or plan that provided similar benefits. Continuous Coverage is discussed at the end of this section;
2. Services for which no charge is normally made including but not limited to services and supplies furnished by the Policyholder's infirmary, its employees or Doctors who work for the Policyholder and services covered and provided by the student health fee;
3. Normal health checkups, preventive testing or treatment, screening exams or testing in the absence of Injury or Sickness except as specifically provided for in this policy;

4. Eye examinations, prescriptions or fitting of eyeglasses and contact lenses, or other treatment for visual defects and problems, unless payable as a Covered Expense associated with an Injury covered by the policy;
5. Hearing examinations or hearing aids, or other treatment for hearing defects and problems, unless payable as a Covered Expense associated with an Injury covered by the policy;
6. Dental Treatment, except as specifically provided for in the policy;
7. War or any act of war, declared or undeclared; or service in the armed forces of any country;
8. Participation in a riot or civil disorder, commission of or attempt to commit a felony, or fighting, except in self-defense;
9. Injury sustained while participating in interscholastic or professional sports contest or competition, including: 1) Traveling to or from such sport, contest or competition as a participant; or 2) During participation in any practice or conditioning program for such sport, contest, or competition; unless specifically provided for in the policy;
10. Skydiving; parachuting or bungi-cord jumping, hang gliding, glider flying, parasailing, sail planing, or flight in any kind of aircraft, except while riding as passenger on a regularly scheduled flight of a commercial airline;
11. Elective surgery and elective treatment, except as required to correct an Injury or Sickness for which benefits are otherwise payable under the policy;
12. Voluntary or Elective Abortion;
13. Any loss covered by state or federal worker's compensation law, employers liability law, occupational disease law, or similar laws or act;
14. That part of medical expense payable by any automobile insurance policy without regard to fault;
16. Preventive medicines, serums, vaccines, unless specifically covered under the policy or otherwise mandated by New York State law;
17. Treatment in a military or Veterans Hospital or a Hospital contracted for or operated by a national government or its agency unless: 1) The services are rendered on an Medical Emergency basis; and 2) A legal liability exists for the charges made to the Covered Person for the services given in the absence of insurance;
18. Treatment or service provided by an Immediate Family Member or for a member of an Insured Person's household for which no charge is normally made;
19. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefit Provisions;
20. Mental or emotional disorders, except as specifically provided by the policy;
21. Inpatient treatment of alcoholism or drug addiction, except as may be provided by the policy.

Continuous Coverage: If a **covered person** was continuously covered under this or a similar preceding policy offered through the Group Policyholder, any **sickness** diagnosed or **injury** sustained while so covered will not be considered a Pre-Existing Condition when such person becomes covered under this Certificate, provided the **covered person** enrolls for this coverage within 63-days of the end of the preceding company's policy. The Covered Person will be considered to have maintained continuous coverage, except for expenses that are the liability of the previous policy. Coverage cannot be considered continuous if a break in enrollment of more than 63-days occurs.

Extension of Benefits: If the Covered Person is under the care and treatment of a Doctor for an Injury or Sickness, benefits will continue to be paid for that condition until the first to occur of: a) a period of up to 3 months following the Covered Person's Term of Coverage; or

b) the maximum benefit on the Policy. **Notice of Claim:** Written notice must be given to Us within 90 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized representative. Notice should include the Policyholder's name and number and the Covered Person's name and address.

Fairmont Specialty Travel Assist Plan

Fairmont Specialty has provided a Travel Assistance Service through Europ Assistance USA (EA) which provides 24 hour services that can help you access emergency assistance when you are traveling 100 or more miles away from home. Europ Assistance USA is there when a crisis strikes to help you obtain the care and attention you need.

Over 850,000 multilingual service professionals stand ready to assist you in 200 countries and territories worldwide.

These services are only eligible for payment or reimbursement if EA is contacted at the time of service and has arranged and/or pre-approved the service. Contact number: (877) 279-1913.

Services provided:

Medical Evacuation up to \$50,000, Medical Repatriation up to \$50,000, Return of Dependent Children up to \$5,000, Return of Mortal Remains up to \$10,000, Return of Traveling Companion up to \$5,000. Other additional services including a Nurse Helpline are also available.

Gallagher Koster Complements

Exclusively from Gallagher Koster, enrolled students have access to the following menu of products at no additional cost. These plans are not underwritten by United States Fire Insurance Company. More information is available at www.gallagherkoster.com.

EyeMed Vision Care

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You will receive a separate EyeMed ID card. There is no waiting period; you can take advantage of the savings immediately upon receipt of your EyeMed ID card. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% to 45% off regular retail pricing. In addition, you can receive discounts from 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons. **You can call 1-866-8EYEMED or go online to www.eyemedvisioncare.com and choose the Access network from the drop down network option.**

Basix Dental Savings

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services. It is important to understand the **Dental Savings Program is not dental insurance**. Basix contracts with dentists that agree to charge a negotiated fee to students covered under your Gallagher Koster plan. You must pay for the services received at the time of service to receive the negotiated rate.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have access to the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will

need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Koster at 800-457-5599.

- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

Full details of the program can be viewed at the website: www.basixstudent.com. Once at the home page, select the link for your school. You may also contact us via email from our website, or by telephone at (888) 274-9961.

CampusFit

College health is all about helping students develop healthy habits for a lifetime. To support your efforts, CampusFit “digitizes” knowledge from registered dietitians and certified fitness instructors to help teach and reinforce mainstream ideas about diet, nutrition, fitness and general wellness.

- The Energy Management section of the site allows a student to easily assess how much energy they are consuming, and expending on a daily basis. It also displays the results in the context of the Food Pyramid so students can see how to improve their food choices.
- The Fitness Works section has dozens of downloadable mp3 files and written exercise routines to help students get more active. Want to run your first 5K? We’ve got a nine week, step-by-step plan to get you there.
- The Wellness Support section has downloadable mp3 files for guided imagery relaxation, and dozens of recordings to reinforce fundamental diet and nutrition ideas – we’ve even got a 20 minute discussion on the “Freshman 15”.

CampusFit is available at no cost to students. To access CampusFit, go to www.gallagherkoster.com.

Subrogation and Reimbursement

In the event that an Insured Person suffers an Injury or Sickness for which another party may be responsible, such as someone injuring the Insured Person in an Accident, and We pay benefits as a result of that Injury or Sickness, We will be subrogated and succeed to the Insured Person’s right of recovery against the responsible party to the extent of the benefits We have paid. This means that We have the right independently of the Insured Person to proceed against the responsible party to recover the benefits We paid.

If benefits are paid under this Policy and any person recovers from a responsible third party by settlement, judgment or otherwise, We have a right to recover from that person an amount equal to the amount We paid. However, We will reimburse the Insured Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

Limited Benefits Health Insurance

The insurance evidenced in this brochure provides limited benefits health insurance Only. It does NOT provide basic hospital, basic medical, major medical insurance, Medicare supplement, long-term care insurance, nursing home insurance Only, home care insurance Only, or nursing home and home care insurance as defined by the New York State Insurance Department.

Appeal Procedure

Internal Appeal

If Your claim is denied, You will be notified of the reason with a description of any additional information necessary to appeal the denial.

If You would like additional information or have a complaint concerning the denial, please contact Klais & Company, Inc., our Third Party Administrator (TPA), at 1-800-331-1096. Klais & Company, Inc. will address concerns and attempt to resolve the complaint. If Klais is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to Klais. Please include Your name, social security number, home address, policy number and any other information or documentation to support the appeal.

The appeal must be submitted within 60 days of the event that resulted in the complaint. Klais will acknowledge Your appeal within 10 working days of receipt or within 72 hours if the involves a life-threatening situation. A decision will be sent to You within 30 days. If there are extraordinary circumstances involved, Klais may take up to an additional 60 days before rendering a decision.

External Appeal

Under New York State Law, You have the right to an External Appeal ONLY when a claim is denied because services are not Medically Necessary or the services are Experimental or Investigational AND You or Your provider must have received a Final Adverse Determination on Your internal appeal OR You and the Plan must have agreed to waive the internal appeal process. A “Final Adverse Determination” means written notification that an otherwise covered health care service has been denied through the internal appeal process.

If a service was denied as Experimental or Investigational, You must have a life-threatening or disabling condition or disease to be eligible for an external appeal AND Your attending physician must submit an Attending Physician Attestation form. An external appeal may only be requested if the denied service is a covered benefit under the plan. Instructions, forms and the fee required for an External Appeal may be found at <http://www.ins.state.ny.us/extamaa.htm>. You must file an External Appeal within 45 days of receipt of a notice of Final Adverse Determination or within 45 days of receiving notice that the internal appeal procedure has been waived. An expedited external appeal will be decided within 3 days of receiving a request from the state. A standard external appeal will be decided within 30 days of receiving the request from the state.

Claims Procedures

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

1. A claim form is not required to submit a claim. However, an itemized medical bill, HCFA 1500, or UB-92 form should be used to submit expenses. The Insured Student/Person’s name and identification number need to be included.
2. The form(s) should be mailed within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to the Claims Administrator, Klais & Company, inc. at the address on the back cover.
3. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Klais & Company, Inc.

Privacy Statement

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic, and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy by calling us toll-free at 1-800331-1096 or by visiting us at www.klais.com.

Questions? Need More Information?

For general information on benefits, enrollment/ eligibility questions, ID cards, brochures or service issues, please contact:

Gallagher Koster

500 Victory Rd.

Quincy, MA 02171

800-457-5599

E mail: Daemenstudent@gallagherkoster.com

www.gallagherkoster.com

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Gallagher Koster to verify eligibility.

For information on a specific claim, or to check the status of a claim, please contact:

Klais & Company, Inc.

1867 West Market Street

Akron, OH 44313

1-800-331-1096

Email: Klaisclaims@klais.com

Register for StatusLink Claims Look-Up at www.klais.com

This plan is underwritten by:

United States Fire Insurance Company

By Fairmont Specialty

A part of Crum & Forster

Policy Number USO10023

Please keep this Certificate as a general summary of the insurance policy. The Master Policy on file at the College contains all the provisions, exclusions and qualifications of your insurance benefits, some of which may not be included in this certificate. The Master Policy is the contract and will govern and control the payment of benefits.