

**ACCIDENT AND SICKNESS
INSURANCE PLAN**

2009-2010 YEAR

Designed Especially for the Students of



Please keep this Summary of coverage for future reference.

Policy No: UCL2777S

Form #MC09

**For questions about this plan please
use the following contact
information:**

Coverage, Eligibility and Premium:

Program Manager

The Allen J Flood Companies Inc.
2 Madison Ave.
Larchmont, NY 10538
1-800-734-9326
www.ajfusa.com

Claim Status and all other Claim Inquiries

Claims Administrator

Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313
1 800-331-1096
www.klais.com

PPO Network Provider List

Beechstreet Network

Online at: www.Beechstreet.com
1.800.432.1776

MultiPlan

Online at: www.multiplan.com
1.800.672.2140

The Plan is underwritten By

United States Fire Insurance Company
by: Fairmont Specialty, a part of
Crum & Forster
Policy No. UCL2777S

**When calling the above toll-free telephone
numbers, please have the name of your
school and the policy number (UCL2777S)
available.**

BASIC STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This brochure is a brief description of the Student Accident and Sickness Insurance Plan for students of Marist College. The exact provisions governing this insurance are contained in the Master Policy issued to Marist College. The Master Policy shall control in the event of any conflict between this brochure and the Policy. This Plan is underwritten by United States Fire Insurance Company and administered by The Allen J. Flood Companies, Inc. **The Policy Number for Accident and Sickness Benefits is UCL2777S.**

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2009. Coverage becomes effective on that date or the date application and full premium is received by the Company, which ever is later. The Master Policy terminates at 12:01 a.m., August 1, 2010 or at the end of the period through which the premium is paid. The spring semester is effective 12:01 a.m. on January 15, 2010 and will terminate at 12:01 a.m. on August 1, 2010. Coverage is in effect 24 hours a day.

ELIGIBILITY

All Full-time students are automatically enrolled in the Basic Student Accident and Sickness Insurance plan as described in this brochure and will be charged for the insurance fee on their tuition bill unless they submit a waiver presenting evidence of their own annual health insurance coverage. The annual rate per student is \$500 and the spring/summer rate is \$300. The rates include an administrative fee.

If you have existing medical insurance coverage under another policy (self, parent, spouse, etc.) – you may waive the Marist College Basic Accident and Sickness Insurance. Please refer to the Marist College Web Site www.marist.edu/financialaid/insurancewaiver for waiver instructions. Please note in order to waive the insurance premium, the student must show proof of other health insurance. The Waiver Deadline is August 3, 2009.

All Full-time students who have **not** waived the Basic Accident and Sickness Insurance have the option to purchase the Enhanced Accident and Sickness Plan to supplement the Basic Accident and Sickness Plan. The

Enhanced Plan includes the Basic Plan benefits of \$25,000, with an additional \$225,000 of coverage, for a total aggregate benefit of \$250,000. Students who elect to purchase the Enhanced Plan will be charged an additional annual premium of \$260 for annual coverage or \$230 for spring/summer coverage. Total premium for both the Basic and Enhanced benefits is \$760.00 annually and \$530.00 for spring/summer coverage. Premium includes an administrative fee.

If you did not waive the Basic Accident and Sickness Coverage and are interested in purchasing the Enhanced medical benefits, please e mail Ron DeLuca at: Rdeluca@ajfusa.com. You must include the following information:

In Subject field please include: **2009-2010 Enhanced Plan for Marist College.**

Also include the following:

- a) Student's first and last name
- b) Student's date of birth
- c) Student's gender
- d) Telephone number where you can be reached
- e) Marist Campus Wide Identification Number (CWID)
- f) Student's complete mailing address
- g) Annual or Spring Summer Term

International Students - are required to have the Enhanced Plan and do not have the option of waiving coverage, in order to ensure that they have adequate insurance coverage while studying in the United States.

Dependent Coverage - Students who are enrolled in the Student Accident and Sickness Insurance Plan may also enroll their Dependents. The term "Dependent" means: (a) the Insured Student's spouse residing with the Insured Student; or (b) the Insured Student's unmarried children under the age of nineteen years; or (c) a child born to an Insured Student while this Plan is in force will be covered by this Plan from the moment of birth. Coverage for such newborn children will consist of coverage for sickness or accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have

dependent coverage when the child is born, We cover the newborn child, for dependent benefits, for the first 31 days from the moment of birth. To continue the child's dependent benefits past the first 31 days, the Insured Student must notify the Plan Administrator in writing within 31 days of the child's birth.

The term children includes an Insured Student's biological children; step-children; adopted children from the date of placement in the Insured Student's home and who depend on the Insured Student for their full support. A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

Dependent Coverage - Students who are enrolled in the Student Accident and Sickness Insurance Plan may also enroll their Dependents.

You may enroll, via the internet using the Program Administrator's website at: www.ajfusa.com. Visa, MasterCard and Discover are acceptable payment methods. The deadline date to enroll on line is September 15, 2009 for the annual coverage and February 10, 2010 for the spring coverage.

You may also enroll by completing the enrollment form online, printing and returning the enrollment form with a check or money order to The Allen J. Flood Companies, Inc. at 2 Madison Avenue, Larchmont, NY 10538. **Please note any enrollments submitted after the deadline will be covered from the date after the Plan Administrator receives both the application and premium. Premiums will not be pro-rated.*

<u>Basic Plan Only</u>		
	<u>Spouse</u>	<u>Per Child</u>
Annual Rate	\$ 972.00	\$ 729.00
Spring/Summer Rate	\$ 580.00	\$ 435.00
<u>Basic & Enhanced plan</u>		
	<u>Spouse</u>	<u>Per Child</u>
Annual Rate	\$1,458.00	\$1,094.00
Spring/Summer Rate	\$1,026.00	\$ 770.00

LATE ENROLLMENT

Students will be able to enroll after the enrollment deadline if they lose coverage under their other comparable health insurance. The student will have to enroll within 63 days in order to avoid a break in coverage (see Pre-existing Condition Limitation). The Insured Student will be covered from the date after the application and premium are received by the Plan Administrator. Premiums will not be pro-rated.

IDENTIFICATION CARDS

Student Identification Cards will be mailed to the student's address which has been provided by Marist College.

PREMIUM REFUND POLICY

Insured Students entering the Armed Forces of any country will not be covered under this Plan as of the date of such entry. Those students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request. Premium received by the Company is fully earned upon receipt. No other requests for a refund of premium will be considered.

DEFINITIONS

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 as shown in the Schedule;
- 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 Schedule.

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 law providing a service covered under the policy. Doctor does not include;

- a. You;
- b. Your spouse, dependent, parent, brother or sister; or
- c. A person who ordinarily resides with You.

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.

Insured Person means an Insured Student and their covered Dependent(s) while insured under this Plan.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Plan.

Loss means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan.

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.

Per Condition Aggregate Maximum means the total amount of benefits payable for each Injury or Sickness under the Student Health Insurance Policy or Policies issued to the Policyholder immediately before this Plan.

Usual, Reasonable and Customary Expense 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.

Sickness means illness, disease, normal pregnancy, and Complication 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.

We, Us or Our means United States Fire Insurance Company

You, Your or Yours means the Insured Student.

PREFERRED PROVIDER NETWORK

Utilizing the Beech Street or the MultiPlan Nationwide Preferred Provider Networks may decrease your out of

pocket costs under this Accident and Sickness Insurance Plan. The Beech Street and MultiPlan Networks consists of hospitals, physicians and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. You are not required to utilize a Beech Street or MultiPlan Providers. In order to use the services of a participating provider you must present your United States Fire Insurance Company Medical Identification Card found at the back of this brochure. An Insured Person may contact:

Beech Street at 1-800-432-1776, toll free number available Monday through Friday, 8:00 a.m. to 8:00 p.m. to receive information on participants in their area, or visit their web site at www.beechstreet.com.

MultiPlan at 1-800-672-2140, toll free number available Monday through Friday, 8:00 a.m. to 8:00 p.m. to receive information on participants in their area, or visit their web site at www.multiplan.com.

EXTENSION OF BENEFITS PROVISION

If a Covered Person is hospital confined and 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 12 months following Your Term of Coverage; or
- b. the maximum benefit shown in the Schedule has been paid.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH & DISMEMBERMENT EXPENSE BENEFITS
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When, because of an Injury, the Insured Person suffers any of the following losses within 365 days from the date of the accident, We will pay as follows:

<u>For Loss of:</u>	<u>Amount</u>
Life	\$1,500
Two hands, two feet, or sight of two eyes	\$1,500
One hand and one foot	\$1,500
One hand and the sight of one eye	\$1,500
One foot and the sight of one eye	\$1,500
One hand or one foot or sight of one eye	\$ 750

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of sight in that eye means total

irrecoverable loss of the entire sight. Only one of the amounts named above will be paid for Injuries resulting from any one accident. The amount so paid shall be the largest amount that applies.

This provision does not cover the loss if it in any way results from or is caused or contributed by: (1) physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by this Plan; (2) an infection, unless it is caused solely and independently by a covered accident; (3) participation in a felony; or (4) the Insured Person being intoxicated or under the influence of any drug unless taken as prescribed by a physician.

**BASIC ACCIDENT
MEDICAL EXPENSE BENEFITS**

If as a result of a covered Injury, an Insured Person incurs Covered Expenses, we will pay 100% of the Usual, Reasonable & Customary Charges incurred up to a Per Condition Aggregate Maximum of \$25,000.00 per Injury. The following Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) inpatient and outpatient consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) pre-hospital medical emergency services; (m) durable medical equipment, prosthetic appliances and orthotic devices; and (n) other expenses incurred for the treatment of an Injury.

**BASIC SICKNESS
MEDICAL EXPENSE BENEFITS**

If as the result of a covered Sickness, an Insured Person incurs Covered Expenses, We will pay the Usual, Reasonable and Customary charges incurred up to an aggregate maximum of \$25,000.00 per Sickness. Benefits will be paid as allocated below.

Hospital Room and Board Expense Benefit: If an Insured Person requires confinement in a hospital, We will pay the Covered Charges incurred up to \$400.00 per day, maximum of 31 days.

Miscellaneous Hospital Expense Benefit: If an Insured Person incurs Expenses during a hospital confinement, or day surgery on an outpatient basis, We will pay the Covered Charges incurred up to a maximum of \$1,500.00, then 80% thereafter, per Sickness. Such Expenses include: (a) anesthesia, anesthesia supplies and services; (b) operating, delivery and treatment rooms and equipment; (c) diagnostic x-ray and laboratory tests; (d) lab studies; (e) oxygen tent; (f) blood and blood services; (g) prescribed drugs and medicines; (h) medical and surgical dressings, supplies, casts and splints; (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; (j) chemotherapy treatment with radioactive substances; (k) intravenous injections and solutions, and their administration; (l) physical and occupational therapy; and (m) other necessary and prescribed hospital expenses.

Surgical Expense Benefit (Inpatient): We will pay up to 80% of the Usual Reasonable and Customary Charges incurred for surgery performed by a licensed Doctor

Second Surgical Opinion Benefit – If an Insured Person incurs expense for a second surgical opinion, we will pay a maximum benefit of \$75.00 per Sickness.

In-Hospital Doctor's Fees and Medical Expense Benefit: If an Insured Person, who is confined as a resident bed-patient in a hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Usual Reasonable and Customary Charges incurred up to \$75.00 per visit, limited to one visit per day, to a maximum of \$750.00.

Outpatient Doctor Visit Expense Benefit: If an Insured Person requires the services of a Doctor, We will pay the Covered Charges incurred up to \$75.00 per visit, limited to one visit per day.

Emergency Room Expense Benefit: When the Insured Sickness requires the use of an emergency room. The Company will pay up to a maximum of \$1,000.00 per Sickness, subject to a \$50.00 copay (waived if admitted).

Outpatient Diagnostic X-ray & Laboratory

Expense Benefit: If an Insured Person is prescribed by an attending Doctor for diagnostic x-ray and laboratory services on an outpatient basis, benefits will be paid under the Outpatient Expense Benefit up to a maximum benefit of \$1,000.00. Benefits include coverage for mammographic examination and cytological screen (pap smear).

Outpatient Prescription Drug Expense Benefit:

After a co-payment of \$15.00 for generic or \$30.00 for a brand name drug (per prescription), up to a \$250.00 per sickness maximum, up to a \$750.00 per policy year maximum, limited to a 31 day supply per prescription at a time. Prescriptions must be filled at a Medco Participating Pharmacy. If you need to have a prescription filled prior to receiving your ID card, pay for the medication in full at the pharmacy and save your receipt. Your Insurance ID Card will include instructions on how to file for reimbursement for prescriptions filled before you receive your card. Prescription claim forms can also be obtained from the Plan Administrator at www.ajfusa.com

After you receive your Insurance ID card, there will be no need to complete a Prescription claim form.

Medications not covered by this benefit include, but are not limited to: topical acne treatments (i.e. Retin-A), fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; blood plasma; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a hospital or rest home. This benefit is provided to cover prescription expenses associated with an Accident or Sickness occurring during the policy year

Ambulance Expense Benefit: If an Insured Person requires the need of an ambulance, we will pay a maximum benefit of \$100.00 per Sickness.

Consultant Expense Benefit: If an Insured Person requires the services of a Consultant, We will pay a maximum benefit of \$250.00 per Sickness.

Elective Abortion Benefit: If as a result of pregnancy having its inception during the term insured, an Insured Person has an elective abortion, we will pay a maximum benefit of \$350.00.

**ENHANCED
ACCIDENT & SICKNESS EXPENSE BENEFIT**

The Enhanced Accident and Sickness Expense Plan begins payment after the Basic Accident and Sickness Expense Benefit of \$25,000.00 have been paid, for each Sickness or Injury. The Company will pay 80% of Usual, Reasonable and Customary Medical Expenses incurred up to the Enhanced Accident and Sickness medical Expense Benefit maximum of \$225,000.00. The total aggregate maximum benefit payable under the Basic and Enhanced Accident & Sickness Expense Benefit is **\$250,000.00** per Accident or Sickness.

All terms and conditions of the basic Benefit will apply to the benefit as well.

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
www.europassistance-usa.com

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.

**ADDITIONAL BENEFITS FOR
BOTH THE BASIC AND ENHANCED PLAN**

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.

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:

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. 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 Usual Reasonable and Customary Charges incurred for up to 60 visits during any one calendar year, for the diagnosis and treatment of Chemical Abuse and 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 Dependence and Chemical Abuse 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 Covered Charges for any other Sickness.

“Chemical Abuse and Chemical Dependence” means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Mammographic 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

Cytologic Screening Expense Benefit: We cover charges for Expenses incurred for an annual Cytologic Screening (Pap smear) for cervical cancer for women eighteen and older. We treat such charges in 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. Cervical cytology screening also includes an annual pelvic examination.

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 in the same way We treat Covered Charges for any other Sickness.

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. If this Plan requires the use of Network Providers, the Insured Person is entitled to a second medical opinion from a non-participating specialist, at no additional cost beyond that which the Insured Person would have paid for services from a participating specialist, provided the Insured Person's attending Doctor provides a written referral. 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.

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 charges the same way We treat any other Covered Charges for any other Sickness.

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.

Diabetes Treatment Expense Benefit: We cover charges for the following Medically Necessary diabetes equipment services 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 any other Covered Charges for a 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 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.

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.

Maternity Expense Benefit: We will pay benefits for an Insured Person's Covered Charges for maternity care, including hospital, surgical and medical care. We treat such charges in the same way We treat Covered Charges for any other Sickness.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a healthcare facility. Covered services may be provided by a certified-nurse midwife, under qualified medical direction, affiliated or practicing in conjunction with a licensed facility, unless the attending Doctor, in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If so, We will cover charges for one home health care visit. The visit must be requested within 48 hours of the delivery (96 hours in the case of a cesarean 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 health 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 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 is covered when the infant is confined in the hospital and has received continuous hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, except circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

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 treat such charges the same way we treat Covered Charges for any other Sickness.

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. We also 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.

Contraceptive Services Expense Benefit: We will pay the Covered Percentage of the Covered Charges for Contraceptive Drugs and Devices. Such Drugs and Devices must be approved by the United States Food and Drug Administration and prescribed legally by an authorized health care provider. Covered services are subject to applicable co-payments under the Prescription Drug Benefit Plan.

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.

EXCLUSIONS

The Plan does not cover nor provide benefits for:

1. Dental treatment except for treatment resulting from Injury to natural teeth.
2. Services normally provided without charge by the College's health center, infirmary, or hospital, or by providers employed by the College.
3. Eyeglasses, contact lenses, hearing aids, or prescriptions or examinations therefore.
4. Injury due to participation in a riot, or attempt to commit a felony;
5. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Injury or Sickness resulting from declared or undeclared war; or any act thereof.
7. Injury or Sickness for which benefits are paid under any Workers Compensation or Occupational Disease Law.
8. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person, upon written request
9. Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. Elective treatment or elective surgery, except as required to correct an Injury or Sickness for which benefits are payable under this policy.
11. Cosmetic surgery, except as the result of covered Injury occurring while this Plan is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.
12. Expenses covered by any other medical, health or accident insurance provided on a group basis. This exclusion shall only apply if the entire

premium for the coverage under this Plan is paid by Marist College, with no contributions from the Insured Student.

13. Injuries sustained as the result of a motor vehicle accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance.
14. Treatment of mental or nervous disorders except as specifically provided.
15. Treatment of alcohol and substance abuse except as specifically provided.
16. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile.
17. Routine physical, preventive medicines, serums, or vaccines, unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Plan.
18. Pre-existing conditions as defined in this Plan.
19. Suicide, attempted suicide, or intentionally self-inflicted Injury.
20. Injury or Sickness caused by, contributed to or resulting from being intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.
21. Foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
22. Accident treatment arising out of Intercollegiate Sports.

PRE-EXISTING CONDITIONS LIMITATION

Pre-Existing Conditions are excluded subject to the provision entitled "Continuous Coverage" shown below. Pre-Existing Condition means any Injury or Sickness or condition manifesting in symptoms during the (3) 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.

CONTINUOUS COVERAGE

If a Covered Person is continuously covered under the policy offered through the Policyholder, he/she will be covered for an Injury sustained or Sickness first manifested while so covered. If You enroll for coverage

offered through Your Policyholder within 63 days of the end of any preceding company's policy, You 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.

COORDINATION OF BENEFITS

When an Insured Person is covered under more than one valid and collectible health insurance plan benefits payable will be coordinated with the other plan. Reimbursement from all plans will never exceed 100%. A complete description of the Coordination of Benefits provision is included in the Master Policy on file with Marist College.

CLAIM PROCEDURES

In the event of an Injury or Sickness:

1. A Company claim form is required for filing a claim. Claim forms are available from the College Health Center. You can also obtain a claim form at [www.marist.edu/healthservices/insurance info](http://www.marist.edu/healthservices/insurance%20info)

Mail the following items to the Claims Administrator at the address below:

- Completed claim form including Insured's name, address, CWID, and the name of the University under which the student is insured.
 - All itemized medical and hospital bills.
 - Drug bills (not cash register receipts) showing prescription number, name of drug, date prescribed and name of person for whom the drug was prescribed.
2. A claim must be submitted within 90 days after an Injury or Sickness has occurred in order for the claim to be considered.

SEND COMPLETED CLAIM TO:

Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313
www.klais.com
1 800-331-1096

EACH CONDITION REQUIRES A SEPARATE CLAIM FORM APPEALS PROCEDURES

External Appeals Procedure

Under New York State Law, an Insured Person has the right to an External Appeal when health care services

are denied by a health insurer on the basis that the services are not Medically Necessary or that the services are Experimental or Investigational.

A “**Final Adverse Determination**” means written notification from the health plan that an otherwise covered health care service has been denied through the plan’s internal appeal procedures.

Eligibility for an External Appeal

To be eligible for an external appeal, an Insured Person or an Insured Person’s provider must have received a Final Adverse Determination as a result of the health plan’s internal review/appeal procedures OR the Insured Person and his/her health plan must have agreed to waive the internal appeal procedures.

If services are denied as Experimental or Investigational, the Insured Person must have a life-threatening or disabling condition or disease in order to be eligible for an external appeal AND his/her attending physician must complete and submit an Attending Physician Attestation form.

An external appeal may only be requested if the service or procedure that was denied is a covered benefit under the plan. The external appeal process cannot be used to expand Eligibility coverage under the plan.

For an Expedited External Appeal

If the attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to an Insured Person’s health, an expedited appeal may be requested. The request must include an Attending Physician Attestation form.

How to Request an External Appeal

An external appeal is requested by completing an application form, attaching a check for \$50.00 payable to **United States Fire Insurance Company** and sending it to the New York State Insurance Department within 45 days of receipt of a notice of Final Adverse Determination or within 45 days of receiving written confirmation from the health plan that the internal appeal procedure has been waived.

Time Frame for Decision

An expedited appeal will be decided by an external appeal agent within three days of receiving a request for an external review from the state.

An external appeal agent will decide a standard appeal within 30 days of receiving the request from the state.

If the external appeal agent overturns the denial, an Insured Person's fee will be refunded.

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 insured's or former insured's 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 through your school, or by calling toll-free at: 1 800-331-1096