ACCIDENT AND SICKNESS INSURANCE PLAN

2011-2012 YEAR

Designed Especially for the Students of

Please keep this summary of coverage for future reference.

Policy No: UEL2777S Form# MC11
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  
Group No. SF707C1  
EDI# 34145

**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

When calling the above toll-free telephone numbers, please have the name of your school. The group number (SF707C1) and the policy number (UEL2777S) available.
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 this Plan is UEL2777S.

EFFECTIVE AND TERMINATION DATES
The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2011. Coverage becomes effective on that date or the date application and full premium is received by the Company, whichever is later. The Master Policy terminates at 12:01 a.m., August 1, 2012 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, 2012 and will terminate at 12:01 a.m. on August 1, 2012. Coverage is in effect 24 hours a day.

ELIGIBILITY
All Full-time undergraduate students are automatically charged for the Basic Student Accident and Sickness Insurance on their tuition bill.

If you have existing medical insurance coverage under another policy (self, parent, spouse, etc.) – you may have the charge for the Marist College Basic Accident and Sickness Insurance removed from your tuition bill. Please refer to the Marist College web site at www.Marist.edu/financialaid/insurance for the waiver instructions. Please note in order to waive the insurance premium the student must show proof of other health coverage. The Deadline to file a Waiver is August 19, 2011.

All Full-time undergraduate 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 provides a total aggregate Benefit of up to $250,000. Students who elect to purchase the Enhanced Plan will be charged an additional premium of $260 for the annual coverage or $230 for spring/summer coverage.

### Premium Rates

#### Annual

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<thead>
<tr>
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<th>08/01/11-08/01/12</th>
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<tbody>
<tr>
<td>Full-time (Basic Plan Only)</td>
<td>$ 500</td>
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<tr>
<td>Full-time Enhanced (In addition to Basic)</td>
<td>$ 260</td>
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<td>Part-time &amp; Graduate (Basic Plan Only)</td>
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<tr>
<td>Part-time &amp; Graduate (Basic &amp; Enhanced)</td>
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<td>Spouse (Basic &amp; Enhanced)</td>
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<td>Per Child (Basic Plan Only)</td>
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<tr>
<td>Per Child (Basic &amp; Enhanced Plan)</td>
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#### Spring

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<td>Full-time Enhanced (In addition to Basic)</td>
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<td>Part-time &amp; Graduate (Basic Plan Only)</td>
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<td>Part-time &amp; Graduate (Basic &amp; Enhanced)</td>
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<tr>
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<td>Spouse (Basic &amp; Enhanced)</td>
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<tr>
<td>Per Child (Basic Plan Only)</td>
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<tr>
<td>Per Child (Basic &amp; Enhanced Plan)</td>
<td>$ 792</td>
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The above rates include an administrative fee.
If you would like to purchase the Enhanced Plan you may do so via the internet using the Program Administrator’s website at www.ajfusa.com. Visa, MasterCard and Discover are acceptable payment methods. **Remember you cannot purchase the Enhanced Plan unless you are also covered under the Basic Accident and Sickness Plan.** The deadline date to enroll on line is September 15, 2011 for the annual coverage and February 10, 2012 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 enrollment deadline will become effective on the day immediately following the date the enrollment form and premium check is received by the Plan Administrator. **Premiums will not be pro-rated.**

**All graduate students and part-time students** are eligible to purchase the Basic and the Enhanced Plan as outlined in this brochure.

If you would like to purchase the Basic or the Basic and Enhanced Plan you may do so via the internet using the Plan Administrator’s website at www.ajfusa.com. Visa, MasterCard and Discover are acceptable payment methods.

You may also enroll by completing the enrollment form online, print and return 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 enrollment submitted after the deadline will become effective the day after the Plan Administrator receives both the application and premium. **Premiums will not be pro-rated.**

**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. This coverage does not apply in the international student’s home country.

**The Marist Health Plan does not have a deductible for Domestic or International students.**

**Dependent Coverage** - Students who are enrolled in the Student Accident and Sickness Insurance Plan may also enroll their Dependents. “Dependent” or “Eligible Dependent” means: the insured's Spouse under age 70; or Child who: (a) is under 26 years of age; and (b) is not provided coverage as a named subscriber, insured, enrollee, or coverage person under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under Title XVII of the Social Security Act, Public Law 89-97, 42 U.S.C. Section 1395 et seq.; or (c) A Child of any age who is medically certified by a Physician as having an intellectual disability or a physical disability and is dependent upon the Insured.

“Spouse” means the lawful Spouse, under age 70 (unless otherwise stated in the Application), of an insured.

“Child” can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

Coverage for 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.

You may enroll your dependents, 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, 2011 for the annual coverage and February 10, 2012 for the spring coverage.

You may also enroll by completing the enrollment form online, printing and returning this 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."
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
All full-time students who were billed for the Student Health Medical Coverage may pick up their Identification Card during move in weekend from the Plan Administrators. Those students who do not pick up their cards at that time can retrieve them from the Student Financial Services Office. Students who purchase the coverage either by mail or on the website will receive an Identification Card by mail at the address provided on the enrollment form.

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 ones 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.

Accident means a specific unforeseen event, which happens while the Insured Person is covered under this Plan and which directly, and from no other cause result in an Injury.
Per Condition Aggregate Maximum means the annual 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 consist 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. 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.

An Insured person may contact 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

<table>
<thead>
<tr>
<th>ACCIDENTAL DEATH &amp; DISMEMBERMENT EXPENSE BENEFITS</th>
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<tbody>
<tr>
<td><strong>For Loss of:</strong></td>
</tr>
<tr>
<td>Life</td>
</tr>
<tr>
<td>Two hands, two feet, or sight of two eyes</td>
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<td>One hand and one foot</td>
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<td>One foot and the sight of one eye</td>
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<td>One hand or one foot or sight of one eye</td>
</tr>
</tbody>
</table>

For Loss of: Life: $5,000
For Loss of: Two hands, two feet, or sight of two eyes: $5,000
For Loss of: One hand and one foot: $5,000
For Loss of: One hand and the sight of one eye: $5,000
For Loss of: One foot and the sight of one eye: $5,000
For Loss of: One hand or one foot or sight of one eye: $5,000

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.
**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 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 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 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, 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 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 per visit, limited to one visit per day, to a maximum of $750.

**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 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 $1,500 per Sickness, subject to a $100 copay (waived if admitted, referred by the UHC or by the On-Call triage nurse).

**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 after a $100 deductible. Benefits include coverage for mammographic examination and cytological screen (pap smear).

**Outpatient Prescription Drug Expense Benefit:** After a co-payment of $15 for generic or $30 for a brand name drug (per prescription), up to a $1,000 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 $500 per Sickness.

Consultant Expense Benefit: If an Insured Person requires the services of a Consultant, We will pay a maximum benefit of $250 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.

**ENHANCED ACCIDENT & SICKNESS EXPENSE BENEFIT**

The Enhanced Accident and Sickness Expense Plan begin payment after the Basic Accident and Sickness Expense Benefit of up to $25,000 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. The total aggregate maximum benefit payable under the Basic and Enhanced Accident & Sickness Expense Benefit is up to $250,000 per Accident or Sickness.

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

**FAIRMONT SPECIALTY TRAVEL ASSIST SERVICES**

The Travel Assist Plan is designed to provide students who travel 100 miles or more from their home (or in a foreign country that is not the country of permanent residence), with worldwide, 24-hour, emergency assistance services during the term of coverage under the student accident and sickness plan. The assistance services are provided by On Call International.

Emergency Medical Transportation Services are provided up to a combined maximum limit of $50,000 for covered services. Key service include: Emergency Evacuation, Medically Necessary Repatriation, Repatriation of Remains, Family of Friend Transportation Arrangements, and Return of Minor Children. All transportation related services; coverage and payments must be arranged and pre-approved by On Call International.

Worldwide emergency medical, legal and travel assistance services are available 24-hours a day, 365 days a year. For Assistance call:
In the U.S. toll free – 1-866-509-7715
Worldwide, collect – 1-603-328-1728

**24-HOUR NURSE ADVICE LINE**

Wouldn’t you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. On Call provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member’s ailments. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-800-850-4556.

**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.
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 apparatus therefor, 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 as 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. Foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.

20. 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

   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.

**The Plan is underwritten by**
United States Fire Insurance Company
Fairmont Specialty, a part of
Crum & Forster
Policy Number: UEL2777S
Master Policy is based on form #AH27261-NY