HOFSTRA UNIVERSITY

Domestic Student Injury and Sickness Insurance Plan

designed for

Hofstra University 2011-2012

Hempstead, NY

Policy Number: GLSP0020-11
Gerber Life Insurance Company Policy Form Number: COL-03-NY

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Student Eligibity

Domestic Resident Hall Student Sickness Only Insurance Plan
All domestic residence hall undergraduate students enrolled at Hofstra University are automatically enrolled in the Domestic Resident Hall Student Sickness Only Insurance Plan. The Domestic Resident Hall Student Sickness Only Insurance Plan provides coverage for Covered Medical Expenses incurred as a result of an Sickness sustained during the academic year, 8/1/11 - 7/31/12.

Voluntary Domestic Student Injury & Sickness Insurance Plan
All full time and qualified part time undergraduate and graduate students are eligible to enroll in the Voluntary Domestic Student Injury & Sickness Insurance Plan on a voluntary basis. The Voluntary Student Injury & Sickness Insurance Plan combines coverage for Covered Expenses incurred as a result of a Sickness with the coverage available under the Domestic Resident Hall Student Sickness Only Insurance Plan. The Voluntary Injury & Sickness Insurance Plan also provides coverage for Emergency Medical Evacuation and Repatriation of Remains. Students who elect to purchase this Plan will be covered by the Voluntary Student Injury & Sickness Insurance Plan for the entire policy year, 8/1/11 through 7/31/12.

Policy Term

Domestic Resident Hall Student Sickness Only Insurance Plan

The Domestic Resident Hall Student Sickness Only Insurance Plan becomes effective on August 1, 2011 and terminates on July 31, 2012. Spring term coverage is effective on January 1, 2012 and terminates on July 31, 2012.

Voluntary Domestic Student Injury & Sickness Insurance Plan

The Voluntary Domestic Student Injury & Sickness Insurance Plan is effective on August 1, 2011 at 12:01 am and terminates on July 31, 2012 at 12:01 a.m. for annual coverage. Spring term coverage is effective on January 1, 2012 at 12:01 a.m. and terminates on July 31, 2012 at 12:01 a.m. Enrollment in the Voluntary Injury & Sickness Insurance Plan extends the Domestic Resident Hall Student Sickness Only Insurance Plan through July 31, 2012.

Online Student Enrollment Process

Students interested in purchasing the Voluntary Domestic Student Injury and Sickness Plan may do so at www.gallagherkoster.com/Hofstra and by clicking on 'Direct Pay Enroll'. The deadline for processing the online enrollment forms is September 30, 2011, for students enrolling in the fall and January 15, 2012, for students who are newly enrolled for the spring term.

Dependent Eligibility and Enrollment

Eligible dependents of students enrolled in the Plan may participate on a voluntary basis. Dependents must be enrolled at the time of the Insured Student's enrollment or within 31 days of birth of the newborn. Eligible dependents are the spouse and unmarried children under 26 years of age and who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student. It is the student's responsibility to enroll eligible dependents by the deadline each year. Dependents are not automatically re-enrolled. Previously enrolled dependents must be re-enrolled for coverage by September 30, 2011, in order to avoid a break in coverage.

The Effective Date for an Insured's eligible spouse or dependents enrolled with an Insured is the Insured's Effective Date provided we receive the required premium for the spouse or dependent by the enrollment deadline. If a spouse or dependent becomes eligible after an Insured's Effective Date, the Insured has 31 days from the date such spouse or dependent first becomes eligible to enroll them and pay the applicable premium.

To submit dependent enrollment information, Insured Students can go to www.gallaghkoster.com/Hofstra and click on "Dependent Enroll" to complete an online Dependent Enrollment Form.

Plan Costs

Term	Annual	Spring Semester	Fall Semester
Coverage Period	8/1/11 - 7/31/12	1/1/12 - 7/31/12	8/1/11 - 12/31/11
Student Only	$866	$509	$357
Spouse Rate Only	$1,722	$1,004	$718
Child(ren) Rate Only	$2,835	$1,653	$1,182
Part Time Student Only	$1,294	$759	$535

Optional Increased Supplemental Expense Benefit

Eligibility: This benefit is optional and requires additional premium. Students must be enrolled in the Voluntary Domestic Student Injury & Sickness Plan to elect this coverage. If the covered medical Expenses for an Injury or Sickness exceeds the maximum paid under the basic Injury or Sickness (Policy Number GLSP0020-11), basic benefit of $100,000, payment will be made for 80% of the remaining covered Injury or Sickness Expenses to a maximum of $150,000. The combined maximums under the basic plan and Increased Supplemental Limit will not exceed $250,000. The total benefits payable for all policy terms for which You are enrolled for the Increased Supplemental Limit will not exceed $250,000 for any one Injury or Sickness. Covered medical Expenses under this coverage will be the same as covered medical Expenses under the basic policy. All other terms and conditions of the basic policy will apply to this coverage as well. Provisions relating to coverage for Pre-Existing Conditions will apply to the Increased Supplemental Limit benefit separately from the basic policy.

	Annual	Spring
Effective Dates	08/1/11 - 07/31/12	01/01/12 - 07/31/12
Student Only	$ 150	

Premium Refund Policy

Except for a withdrawal due to an Injury or Sickness, any Insured Student withdrawing from the school during the first 31 days of the period for which coverage is purchased shall not be covered under the Plan and a full refund of the premium will be made. Students withdrawing after 31 days will remain covered under the Plan for the full period for which the premium has been paid and no refund will be made available. This also applies to students on leave for academic reasons, graduating students, and students electing to enroll in another plan during the policy year.

Coverage for an Insured Student entering the Armed Forces of any country will terminate as of the date of such entry. Those Insured Students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request. Premiums received by the Company are fully earned upon receipt and are non-refundable except as specifically provided.

Gallagher Koster Complements

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

EyeMed Vision Care

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

Basix Dental Savings

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services. It is important to understand the ***Dental Savings Program is not dental insurance.*** Basix contracts with dentists that agree to charge a negotiated fee to students covered under your Gallagher Koster plan. You must pay for the services received at the time of service to receive the negotiated rate. Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have access to the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Koster at 800-457-5599.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

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

CampusFit

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

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

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

Prescription Drug Program

The outpatient prescription drug benefit is available through the Express Scripts Pharmacy Network. The Express Scripts Pharmacy Network includes national pharmacy chains, CVS, Walgreens, Brooks and local pharmacies. After a per prescription co-payment of $10.00 for a 30 day supply of a generic drug and a per prescription co-payment of $25.00 for a 30 day supply of a brand name drug, up to a maximum benefit of $2,500 per policy year. Insured Persons will be given an ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving an ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Gallagher Koster). A listing of Express Scripts Pharmacies is available by calling 1-800-711-0917 or by viewing www.express-scripts.com. Not all medications are covered (See Exclusion Section).

Mail Service Prescription Drug Program

Medications that are taken for a chronic condition can be filled for up to a 90-day supply using Medco's Mail Service Prescription Drug Program. Medications that are taken for a chronic condition can be filled for up to a 90-day supply using Express Scripts Mail Service Prescription Drug Program. Using the Mail Service Prescription Drug Program, a 90-day supply of a medication can be filled with a copayment that is 2 times the copayment of a 30-day supply. When you use the Mail Service Prescription Drug Program you will need to complete a "Express Scripts by Mail" Order Form and mail it directly to Express Scripts along with your doctor's signed prescription form. After submitting your initial prescription, additional prescriptions can be filled by going online to www.Express-Scripts.com. A brochure describing the Mail Service Prescription Drug Program, and order forms, are available at www.gallagherkoster.com/hofstra.

Health and Wellness Center

http://www.hofstra.edu/studentaffairs/studentservices/welctr/

Republic Hall, North Campus

Phone: (516) 463-6745

Fax: (516) 463-5161

During the Summer Break

The Health and Wellness Center will be **OPEN** from:

May 21 2011 through **Sept 1, 2011**

Monday through Thursday from **9 a.m. to 4:45 p.m.**

Fridays 9 a.m. to 3:45 p.m.

- I*n the event of an emergency call Public Safety @ ext* 36606 *or* 516-463-6606
- Normal Business hours will resume on September 6, 2011 as described below

The **Hofstra University Health and Wellness Center** is located on the north side of campus in Republic Hall. **During the academic year,** the Health and Wellness Center is open:

- **Monday through Thursday: 10 a.m. - 6:45 p.m.**
- **Friday, Saturday and Sunday: 10 a.m. – 5:45 p.m.**

Physicians, Nurse Practitioners and Registered Professional Nurses staff the Hofstra Health and Wellness Center. Appointments may be scheduled by calling the Health and Wellness Center at (516) 463-6745. Some specialty care is also available. A current Hofstra I.D. must be presented at each visit. All medical care provided by our doctor, nurse practitioners and nurses is confidential and information is only released at the written request of the student per visit.

Preferred Provider Network

The Hofstra University Student Injury and Sickness Insurance Plan provides access to Physicians, nurse practitioners, and registered professional nurses, hospitals and other health care providers through the Multiplan Preferred Provider Network within the New York area, as well as throughout the United States. Network Providers are the Physicians, Hospitals and other health care providers who are contracted to provide specific medical care at negotiated prices. When Insured Students use Network Providers, out-of-pocket expenses will be less because Network Providers have agreed to accept a negotiated fee or Preferred Allowances as payment. Non-Network Providers have not agreed to a negotiated fee and are subject to a higher coinsurance.

It is important that the Insured Student verify that his or her Physicians are Network Providers when calling for an appointment or at the time of service. The most efficient and accurate way to identify Network Providers is to call Multiplan at 1-888-342-7427 or at www.multiplan.com.

24-hour Nurse Advice Line

Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL INTERNATIONAL, Inc. 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. This program gives Insured students access to a toll-free nurse information line 24-hours a day, 7 days a week. To access a wealth of useful health care information, contact the Nurse Advice Line at 1-800-850-4556.

Definitions

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

Covered Medical Expenses means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any. Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

Custodial Care means help in transferring, eating, dressing, bathing, toileting, and other such related services.

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

Elective Surgery or Elective Treatment includes any surgery and/or treatment which is deemed not to be a Medical Necessity for the treatment of an Injury or Sickness.

Hospital means a short-term, acute, general hospital, which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; 6) if located in New York state, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97, (42 USCA 1395x[k]0; and 7) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, education, or rehabilatory care.

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

Injury means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; unrelated to any pathological, functional, or structural disorder; a source of loss; 4) treated by a Physician within 30 days after the date of Injury; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one Injury, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

Insured Person means: 1) the Named Insured. The term "Insured" also means Insured Person.

Medical Emergency means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

1) Placing the health of the Insured's or others in serious jeopardy;
2) Serious impairment of bodily functions;
3) Serious dysfunction of any body organ or part; or
4) Serious disfigurement of the Insured.

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

Medical Necessity means those services or supplies provided or prescribed by a Hospital or Physician which are:

1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;

3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured, or the Insured's Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured.

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

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

Mental and Nervous Disorder means a Sickness that is a mental, emotional or behavioral disorder. All diagnoses classified as a "Mental Disorder" according to the (International Classification of Diseases) are considered one Sickness.

Named Insured means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

Newborn Infant means: 1) any newly born child of an Insured provided that the person is insured under this policy; 2) a newborn adopted child of an Insured provided the person is insured under this policy on the date the adoption is effective; and 3) a newborn child placed with the Insured pending adoption procedures provided the person adopting the child is insured under the policy on the date the child is placed with the Insured. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

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

Physician means a legally qualified licensed practitioner of the healing arts, including a chiropractor, nurse practitioner, physician's assistant, registered professional nurses who provides care within the scope of his/her license, other than a member of the person's immediate family. The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

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

Pre-Existing Condition means any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6 (or less) months immediately prior to the Insured's enrollment date under the policy.

Prescription Drugs means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

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

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

Sickness means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

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

Usual and Customary Charges means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges. **You, Your,** or **Yours** means the Insured .

We, Us, Our or **The Company** means Gerber Life Insurance Company.

Pre-existing Conditions

A Pre-existing Condition is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended or received by a Physician during the six (6) consecutive months prior to the Effective Date of the Insured Person's coverage under this Policy. This Voluntary Domestic Injury & Sickness Insurance Plan for 2011-12 does not have a waiting period for pre-existing conditions.

Creditable Coverage

Creditable Coverage means coverage under any of the following:

(a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include Injury only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(b) The federal Medicare Program pursuant to Title XVIII of the Social Security Act;

(c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

(d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;

(e) a medical care program of the Indian Health Service or of a tribal organization;

(f) a state health benefits risk pool;

(g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;

(h) a public health plan as defined by federal regulations; or

(i) a health benefit plan under section 5(e) of the Peace Corps Act.

Exceptions

The Pre-existing Condition exclusion does not apply to genetic information, in the absence of a diagnosis of a condition related to such information.

Emergency Medical Evacuation

This benefit is available to International Students or students participating in a Hofstra University Study Abroad Program. Combining this benefit with the Repatriation of Remains benefit, we will pay for benefits for the Covered Expenses incurred, up to $50,000 if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. Emergency Medical Evacuation means: a) the Insured Person's medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital or home residence where appropriate medical treatment can be obtained; orb) for International Students after being treated at a local Hospital; the Insured Person's medical condition warrants Transportation to his/her Home Country to obtain further medical treatment to recover. All Transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company (On Call International). Expenses for special transportation must be: (a) recommended by the attending Physician; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Physician.

Repatriation of Remains

This benefit is available to International Students or students participating in a Hofstra University Study Abroad Program. In the event of the death of an Insured Person, we will pay the actual charges up to a maximum of $50,000 (in conjunction with the Medical Evacuation Benefit) for preparation and transportation of the Insured Person's remains to his or her home country. This will be in accord with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit. Covered expenses include expenses for embalming, cremation, coffins, and transportation. Repatriation of remains must be approved in advance by the Company.

Travel Assistance Services

Included in this health insurance program is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuation and repatriation.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact *On Call International* for any of these services:
Toll Free from U.S. and Canada: 1-800-850-4556
Dial Direct or Call Collect Worldwide: 1-603-898-9159 or
www.oncallinternational.com.

INJURY AND SICKNESS SCHEDULE OF BENEFITS

The Plan provides benefits for the expenses incurred by an Insured Person for loss due to Injury and Sickness up to a Per Condition Maximum of $100,000. Benefits will be paid for each service as scheduled below

ACCIDENT AND SICKNESS BENEFITS	In-Network	Out-of-Network
Aggregate Maximum (per cause)	$ 100,000	
Deductible	$100 (Per Policy Year)	$200 (Per Policy Year)
Health and Wellness Center Referral	Yes (deductible waived if Health and Wellness Center referral provided)	
Out of Pocket Expense Maximum	$5,000	$ 10,000
Inpatient Benefits		
Hospital Room & Board Expense (Daily semi-private room rate)	80% of Preferred Allowance	60% of Allowable Charge
Intensive Care Unit Expense	80% of Preferred Allowance	60% of Allowable Charge
Miscellaneous Hospital Expense	80% of Preferred Allowance	60% of Allowable Charge
Routine Newborn Care Expense (4 days maximum of hospital confinement)	Paid as any other sickness	
Physical Therapy Expense	80% of Preferred Allowance	60% of Allowable Charge
Surgeon's Fees Expense	80% of Preferred Allowance	60% of Allowable Charge
Anesthetist Expense	25% of the Surgery Allowance	25% of the Surgery Allowance
Registered Nurse's Services Expense	80% of Preferred Allowance	60% of Allowable Charge
Physician's Visits Expense	80% of Preferred Allowance	60% of Allowable Charge
Pre-admission Testing Expense	80% of Preferred Allowance	60% of Allowable Charge
Inpatient Psychotherapy Expense	Paid as any other sickness	
Outpatient Benefits		
Surgeon's Fees Expense	80% of Preferred Allowance	60% of Allowable Charge
Day Surgery Miscellaneous Expense	80% of Preferred Allowance	60% of Allowable Charge

INJURY AND SICKNESS SCHEDULE OF BENEFITS (Con't)

Outpatient Benefits (Con't)	**In-Network**	**Out-of-Network**
Anesthetist Expense	80% of Preferred Allowance	60% of Allowable Charge
Physician's Visits Expense (not subject to the deductible) in network only (includes physician assistant and/or nurse practitioner, registered professional nurses)	100% of Preferred Allowance after a $15 copayment	60% of Allowable Charge
Diagnostic X-ray & Laboratory Expense(not subject to the deductible if related to, or ordered by the physician, physician assistant or nurse practitioner, registered professional nurses) in network only	100% of Preferred Allowance	60% of Allowable Charge
Medical Emergency Expense (Co-payment per visit: $100, if not admitted)	80% of Preferred Allowance	60% of Allowable Charge
Physiotherapy Expense	80% of Preferred Allowance	60% of Allowable Charge
Radiation Therapy and Chemotherapy Expense	80% of Preferred Allowance	60% of Allowable Charge
Tests & Procedures Expense	80% of Preferred Allowance	60% of Allowable Charge
Psychotherapy Expense	Paid as any other sickness	
Prescription Benefit Manager (PBM)/Drug Card Program ***Not subject to the policy year deductible****	After Co-payments of: $10 per generic prescription; $25 per brand named prescription. Benefit Maximum: $2,500 per Policy Year	
Additional Benefits		
Ambulance Expense	80% of R&C	
Consultant Expense	80% of Preferred Allowance	60% of Allowable Charge
Accidental Dental	80% of R&C	
Durable Medical Equipment Expense	80% of R&C	
Alcoholism/Drug Abuse Expense	80% of Preferred Allowance	60% of Allowable Charge
Maternity/Complications of Pregnancy	Paid as any other sickness	Paid as any other sickness
Voluntary Termination of Pregnancy	Paid at 100% up to $300 per policy year	
Intercollegiate Sports Expense (Benefit Maximum: $2,000) ***Student athletes will not be subject to the deductible for intercollegiate sports injuries when a claim form/incident report is submitted by the University's/College's personnel.***	100% of Preferred Allowance	80% of Allowable Charge
Accidental Death & Dismemberment	Principal Sum: $10,000	
Wellness Benefit up to $400 per policy year and subject to the deductible To include coverage for: Routine Adult Exams, HPV vaccines, Acupuncture (when provided in a licensed physician's office), Hepatitis B vaccinations, Meningitis vaccination, and diagnostic cultures ordered in the diagnosis or ruling out of sexually transmitted diseases.	100% of Preferred Allowance after $15 copayment per visit	60% of Allowable Charge
Mandated Benefits		
Bone Mass Measurement	Paid as any other Sickness	
Breast Reconstruction	Paid as any other Sickness	
Cytological Screening (pap smear)	Paid as any other Sickness	
Diabetes Treatment	Paid as any other Sickness	
Mammographic Examination	Paid as any other Sickness	
Maternity Care	Not less than 48 hours for normal deliver, and not less than 96 hours for caesarean section delivery	
Mastectomy Treatment	Length to be determined by attending physician	
Clinical Trials	Paid as any other sickness	
End of Life Care Expense	Paid as any other Sickness	
Prostate Screening	Paid as any other Sickness	
Cancer - Second Opinion Expense Benefit	Paid as any other Sickness	
Home Health Care	Paid as any other Sickness	
Enteral Formulas Expense Benefit	Paid as any other Sickness Up to $2,500 per Policy Year	
Travel Assistance		
Medical Evacuation Expense Benefit	100% of Covered Expenses up to $50,000	
Repatriation of Remains Benefit	100% of Covered Expenses up to $50,000	

State Mandated Benefits

Autism Spectrum Disorder Expense Benefit

We will pay the covered percentage of the Covered Medical Expenses incurred by an Insured Person for the diagnosis and treatment of medical conditions otherwise covered by the policy because the treatment is provided to diagnose or treat autism spectrum disorder. We cover such charges the same way We treat Covered Medical Expenses for any other Sickness. **"Autism Spectrum Disorder"** means a neurobiological condition that includes autism, Asperger syndrome, Rett's syndrome, or pervasive developmental disorder.

Breast Cancer Treatment Expense Benefit

Benefits will be paid the same as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured for a lymph node dissection, a lumpectomy or mastectomy for the treatment of breast cancer. Breast reconstructive surgery after a mastectomy will also be paid as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured. Benefits will be paid for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and any physical complications of all stages of mastectomy, including lymphedemas. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Bone Mineral Density Measurements or Tests Expense Benefit

Benefits will be paid the same as any other Sickness for bone mineral density measurements or tests, and if coverage for Prescription Drugs, drugs and devices is otherwise provided in the policy, coverage for federally approved Prescription Drugs and devices.

Bone mineral density measurements or tests, drugs and devices shall include those covered under Medicare as well as those in accordance with the criteria of the national institutes of heath, including, as consistent with such criteria, dual-energy x-ray absorptiometry.

Individuals qualifying for benefits shall at a minimum, include individuals:

(a) previously diagnosed as having osteoporosis or having a family history of osteoporosis; or

(b) with symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; or

(c) on a prescribed drug regimen posing a significant risk of osteoporosis; or

(d) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; or

(e) with such age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Chiropractic Care Expense Benefit

We will pay the covered percentage of the Covered Medical Expenses incurred for chiropractic care, provided by a doctor of chiropractic, in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. We cover such charges the same way We treat Covered Medical Expenses for any other Injury.

Cervical Cytological Screening and Mammograms Expense Benefit

Benefits will be paid the same as any other Sickness for cervical cytology screening and mammograms.

(a) Benefits will be paid for an annual cervical cytology screening for women (18) eighteen years of age and older. This benefit shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

(b) Benefits will be paid for mammograms as follows:

(1) Upon a Physician's recommendation, Insureds at any age who are at risk for breast cancer or who have a first degree relative with a prior history of breast cancer, and

(2) a single base line mammogram for Insureds age 35 but less than 40, and

(3) a mammogram every year for Insureds age 40 and older. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Chemical Dependence Treatment (Alcohol and Drug Abuse) Expense Benefit

Benefits will be paid the same as any other Sickness for treatment of Chemical Dependence and Chemical Abuse subject to the following limits:

Outpatient Treatment:

Outpatient benefits are limited to one outpatient visit per day and include the following:

(a) up to a maximum of 20 outpatient visits per calendar year for the Insured Person in need of treatment;

Inpatient Treatment:

For rehabilitation services, benefits will be paid the same as any other Sickness not to exceed 30 days of inpatient care per policy year.

Benefits will be limited to facilities in New York state certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clinic or medically supervised ambulatory substance abuse programs and in other states to those which are accredited by the joint commission on accreditation of hospitals as alcoholism or Chemical Dependence treatment programs.

"Chemical abuse" means alcohol and substance abuse. **"Chemical dependence"** means alcoholism and substance dependence.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Contraceptive Drugs and Devices Services Expense Benefit

We will pay the covered percentage of the Covered Medical Expenses incurred for the cost of contraceptive drugs or devices approved by the federal food and drug administration or generic equivalents approved as substitutes by such food and drug administration under the prescription of a health care provider legally authorized to prescribe under title eight of New York Education Law. We cover such charges the same way We treat Covered Medical Expenses for any other Sickness.

Diabetes Expense Benefit

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of diabetes. Such equipment and supplies must be recommended or prescribed by a Physician. Covered Medical Expenses includes but are not limited to the following equipment and supplies:

(a) lancets and automatic lancing devices;

(b) glucose test strips;

(c) blood glucose monitors;
(d) blood glucose monitors for the visually impaired;
(e) control solutions used in blood glucose monitors;
(f) diabetes data management systems for management of blood glucose;
(g) urine testing products for glucose and ketones;
(h) oral anti-diabetic agents used to reduce blood sugar levels;
(i) alcohol swabs;
(j) syringes;
(k) injection aids including insulin drawing up devices for the visually impaired;
(l) cartridges for the visually impaired;
(m) disposable insulin cartridges and pen cartridges;
(n) all insulin preparations;
(o) insulin pumps and equipment for the use of the pump including batteries;
(p) insulin infusion devices;
(q) oral agents for treating hypoglycemia such as glucose tablets and gels; and
(r) glucagon for injection to increase blood glucose concentration. Benefits will also be paid for medically necessary diabetes self-management education and education relating to diet. Such education may be provided by a Physician or the Physician's staff as a part of an office visit. Such education when provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral by a Physician may be provided in a group setting. When medically necessary, self-management education and diet education shall also include home visits.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

End of Life Care for Terminally Ill Cancer Patients Expense Benefit

Benefits will be paid the same as any other Sickness for Covered Medical Expenses for acute care services at Hospitals specializing in the treatment of terminally ill patients for those Insured's diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the Insured's attending Physician) if the Insured's attending Physician, in consultation with the medical director of the Hospital, determines that the Insured's care would appropriately be provided by the Hospital.

If the Company disagrees with the admission of or provision or continuation of care for the Insured at the Hospital, the Company will initiate an Expedited External Appeal. Until such decision is rendered, the admission of or provision or continuation of the care by the Hospital shall not be denied by the Company and the Company shall provide benefits and reimburse the Hospital for Covered Medical Expenses. The decision of the External Appeal Agent shall be binding on all parties. If the Company does not initiate an Expedited External Appeal, the Company shall reimburse the Hospital for Covered Medical Expenses.

The Company shall provide reimbursement at rates negotiated between the Company and the Hospital. In the absence of agreed upon rates, the Company will reimburse the Hospital's acute care rate under the Medicare program and shall reimburse for alternate level care days at seventy-five percent of the acute care rate. Payment by the Company shall be payment in full for the services provided to the Insured. The Hospital shall not charge or seek any reimbursement from, or have any recourse against an Insured for the services provided by the Hospital except for any applicable Deductible, copayment or coinsurance.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Maternity Expense Benefit

Benefits will be paid the same as any other Sickness for pregnancy. Benefits will include coverage for an Insured mother and newborn confined to a Hospital as a resident inpatient for childbirth, but, in no event, will benefits be less than:

1. 48 hours after a non-cesarean delivery; or
2. 96 hours after a cesarean section. Benefits for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. The Company will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Physician.

Benefits will be paid for:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. the performance of any necessary maternal and newborn clinical assessments.

In the event the mother chooses an earlier discharge, at least one home visit will be available to the mother, and not subject to any deductibles, coinsurance, or copayments.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) shall be conducted within 24 hours following:

1. discharge from the Hospital; or
2. the mother's request; whichever is later.

Except for the one home visit after early discharge, all benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Medical Foods Expense Benefit

Benefits will be paid the same as any other Sickness for Prescription Drugs for the cost of enteral formulas for home use which are prescribed by a Physician as medically necessary for the treatment of specific diseases for which enteral formulas have been found to be an effective form of treatment. Specific diseases for which enteral formulas have been found to be an effective form of treatment include, but are not limited to inherited disease of amino-acid or organic metabolism; Crohn's disease; gastroesophagael reflux with failure to thrive, disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death.

Benefits will also be paid for the medically necessary Usual and Customary Charges for modified solid food products that are low protein or which contain modified protein for treatment of certain inherited diseases of amino acid and organic acid metabolism not to exceed a maximum benefit of $2,500 in any 12-month period.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Prescription Drugs for the Treatment of Cancer Expense Benefit

Benefits will be paid the same as any other Sickness for Prescription Drugs for the treatment of cancer provided that the drug has been recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information; or
3. the United States Pharmacopeia Drug Information; or

4. recommended by review article or editorial comment in a major peer reviewed professional journal.

Benefits will not be paid for any experimental or investigational drugs or any drug which the food and drug administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Prostate Cancer Screening Expense Benefit

Benefits will be paid the same as any other Sickness for a prostate examination and laboratory tests for cancer for an Insured at any age with a prior history of prostate cancer; at age 50 and over for Insureds who are asymptomatic; and at age 40 and over for Insureds with a family history of prostate cancer or other prostate cancer risk factors. Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Second Medical Opinion for Diagnosis of Cancer Expense Benefit

Benefits will be paid the same as any other Sickness for a second medical opinion by an appropriate Physician, including but not limited to a Physician affiliated with a specialty care center for the treatment of cancer, 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.

Benefits will be paid at the Preferred Provider In-Network level of benefits for a second medical opinion by a non-participating Physician, including but not limited to a Physician affiliated with a specialty care center for the treatment of cancer, when the attending Physician provides a written referral to a non-participating Physician. If the Insured receives a second medical opinion from a non-participating Physician without a written referral, benefits will be paid at the Out-of-Network level of benefits.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Mental, Nervous or Emotional Disorders

Inpatient Hospital Confinement: If an Insured Person requires treatment for a Mental, Nervous or Emotional Disorders, We will pay for such treatment as follows: When the Insured Person requires Hospital Confinement for treatment of a Mental, Nervous or Emotional Disorder, We will pay the covered percentage of the Covered Medical Expenses incurred for such Hospital Confinement on the same basis as any other Sickness as described in Part A, Hospital Room and Board Expense of the Hospital Expense Benefit. However, We will not cover more than thirty (30) days of inpatient care for such services in any one calendar year. Such confinement must be in a licensed or certified facility, including Hospitals. What We pay is shown in the Schedule of Benefits.

Outpatient Services: When an Insured Person is not so Hospital confined, We will pay the covered percentage of the Covered Medical Expenses incurred for not more than 20 days of active treatment in any calendar year, as shown in the Plan of Insurance, for covered outpatient services for the treatment of Mental, Nervous or Emotional Disorders. The Mental, Nervous or Emotional Disorder must, in the professional judgment of health care providers, be treatable, and the treatment must be Medically Necessary. Outpatient Treatment and Physician services include charges made in a facility operated by the Office of Mental Health, or by a psychiatrist or psychologist licensed to practice in this state or a professional corporation or university faculty practice corporation. We cover such charges the same way We treat Covered Charges for any other Sickness. What We pay is shown in the Schedule of Benefits

We will not pay for: (a) Mental health benefits or services for individuals who are presently incarcerated, confined or committed to a local correctional facility or a prison, or a Custodial Care facility for youth operated by the Office of Children and Family Services; (b) Mental health benefits or services solely because such services are ordered by a court; (c) Benefits or services deemed cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs. In addition to the above, this provision is subject to the Exclusions and Limitations of this Policy.

Pre-Hospital Emergency Medical Services Expense Benefit

We will pay the covered percentage of the Covered Medical Expenses incurred for the treatment of an emergency condition when such services are provided by an ambulance service issued a certificate to operate pursuant to section three thousand five of the public health law.

Payment by the Company pursuant to this section shall be payment in full for the services provided. An ambulance service reimbursed pursuant to this section shall not charge or seek any reimbursement from, or have any recourse against the Insured for the services provided pursuant to this paragraph, except for the collection of copayments, coinsurance or deductibles for which the Insured is responsible for under the terms of the policy.

Accidental Death and Dismemberment Benefit

If such Injury shall independently of all other causes and within 365 days from the date of Injury solely result in any one of the following specific losses, the Company will pay the applicable amount below. Payment under this benefit will not exceed the Per Condition Maximum.

For the Loss of	Amount
Life	$10,000
Two hands	$10,000
Two feet	$10,000
Sight of two eyes	$5,000
One hand and one foot	$5,000
One hand and sight of one eye	$5,000
One foot and sight of one eye	$5,000
One hand or one foot or one eye	$5,000

„Loss of hands and feet means the loss at or above the wrist or ankle joints. loss of eyes 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: (a) By 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 Policy; (b) By an infection, unless it is caused solely and independently by a covered Injury; (c) By participation in a felony; or (d) By the Insured Person being intoxicated or under the influence of any drug unless taken as prescribed by a Physician.

In addition to the above, this provision is subject to the Exclusions and Limitations of this Policy.

Exclusions

1. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth;

2. Services normally provided without charge by the Policyholder health service, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
3. Eyeglasses, contact lenses, hearing aids, or prescriptions or examinations therefore;
4. Injury due to participation in a riot;
5. Injury 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;
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 specifically provided;
11. Cosmetic surgery, except as the result of an Injury occurring while this Policy 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. 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;
13. Routine physicals, preventive medicines, serums, vaccines, unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Policy; except as specified in the policy
14. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
15. For expenses as a result of participation in a felony;
16. Illness, Injury, treatment or medical condition arising out of interscholastic or intercollegiate sports in excess of $2,000;
17. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile;
18. Pre-Existing Conditions as defined in this Policy.

Coordination of Benefits

This is a Primary Plan for insured students. However, if it is indicated that the student has other insurance coverage, benefits will be coordinated with any other medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

Extension of Benefits after Termination

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

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. .If the Insured is also an Insured under the succeeding policy issued to the Policyholder; this "Extension of Benefits" provision will not apply.

Subrogation and Right of Recovery

Subrogation - When benefits are paid to or for an Insured under the terms of this policy, the Company shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such Insured for Hospital, medical, or surgical services and benefits. The right of subrogation will only be exercised by the Company when the amounts (or portion) received by the Insured through a third-party settlement or satisfied judgment is specifically identified as amounts paid for Hospital, medical or surgical services and benefits. Such subrogation rights shall extend only to the recovery by the Company of the benefits it has paid for such hospitalization and treatment. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

Right of Recovery - Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

Limited Benefits Health Insurance

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

Appeal Procedure

Internal Appeal

If Your claim is denied You will be notified of the reason with a description of any additional information necessary to appeal the denial. If You or would like additional information or have a complaint concerning the denial, please contact Our Third Party Administrator (TPA) at 1-800-753-1000. The TPA will address concerns and attempt to resolve the complaint. If the TPA is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to Our TPA. Please include Your name, social security number, home address, policy number and any other information or documentation to support the appeal. The appeal must be submitted within 60 days of the event that resulted in the complaint. The TPA will acknowledge Your appeal within 10 working days of receipt or within 72 hours if the event involves a life-threatening situation. A decision will be sent to You within 30 days. If there are extraordinary circumstances involved, the TPA may take up to an additional 60 days before rendering a decision.

External Appeal

Under New York State Law, You have the right to an External Appeal ONLY when a claim is denied because services are not Medically Necessary or the services are Experimental or Investigational AND

You or Your provider must have received a Final Adverse Determination on Your internal appeal OR You and the Plan must have agreed to waive the internal appeal process. A "Final Adverse Determination" means written notification that an otherwise covered health care service has been denied through the internal appeal process.

If a service was denied as Experimental or Investigational, You must have a life-threatening or disabling condition or disease to be eligible for an external appeal AND Your attending physician must submit an Attending Physician Attestation form. An external appeal may only be requested if the denied service is a covered benefit under the plan. Instructions, forms and the fee required for an External Appeal may be found at http://www.ins.state.ny.us/extappqa.htm.

You must file an External Appeal within 45 days of receipt of a notice of Final Adverse Determination or within 45 days of receiving notice that the internal appeal procedure has been waived. An expedited external appeal will be decided within 3 days of receiving a request from the state. A standard external appeal will be decided within 30 days of receiving the request from the state.

Claims Procedures

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

1. If, at the University, and the Health and Wellness Center is open, please call the Health and Wellness Center so that proper treat-ment can be prescribed or approved, or
2. If away from the University, and the Health and Wellness Center is closed, consult a Physician and follow his/her advice.
3. **A claim form is not required to submit a claim**. However, an itemized medical bill, HCFA 1500, or UB-92 form should be used to submit expenses by the provider of service. The Insured Student/Person's name and identification number need to be included.
4. The form(s) should be mailed within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to the Claims Administrator, Co-ordinated Benefit Plans, Inc. at the address on the back cover.
5. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Co-ordinated Benefit Plans.

HIPAA Notice of Privacy Practices for Personal Health Information

Under HIPAA's Privacy Rule, We are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment materials. If, at anytime, you wish to request a copy of Gerber Life Insurance Company's Privacy Notice, write to Gerber Life Insurance Company 1311 Mamaroneck Avenue White Plains, NY 10605 Attn: Privacy Compliance Office Legal Department or on-line at https://www.gerberlife.com/gl/view/legalsite/privpractice.jsp.

Questions? Need More Information?

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

Gallagher Koster
500 Victory Road
Quincy, MA 02171
877-554-5523
Email: hofstrastudent@gallagherkoster.com

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

Co-ordinated Benefit Plans LLC
18167 US Highway 19 North
Suite 450
Clearwater, FL 33764
1-866-224-4494 or
email: Team2@CBPinsure.com
Please submit claims to:
Co-ordinated Benefit Plans
PO BOX 21536
Eagan, MN 55121
NPI(Payer ID) 14829

This Policy is Underwritten by:

Gerber Life Insurance Company
Policy Number: GLSP0020-11
Policy Form Number: COL-03-NY