

**ACCIDENT AND SICKNESS
INSURANCE PLAN**

2010-2011

Designed Especially for the Students of



Please keep this Summary of coverage for future reference.

Policy# UDL3590S

Form #MCC10

**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
Group # SF731A0
www.klais.com
EDI Payer # 34145

PPO Network Provider List:

Beechstreet Network

Online at: www.Beechstreet.com
1.800.432.1776

MultiPlan Network

Online at: www.Multiplan.com
1.800.672.2140

When calling the above toll-free telephone
numbers, please have the name of your school
and the policy number (UDL3590S)
available.

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

This brochure is a brief description of the Student Accident and Sickness Insurance Plan for students of Monroe Community College. The exact provisions governing this insurance are contained in the Master Policy issued to Monroe Community College. The Master Policy shall control in the event of any conflict between this brochure and the Policy. This Plan is underwritten by United States Fire Insurance Company and administered by The Allen J. Flood Companies, Inc. **The Policy Number for Accident and Sickness Benefits is UDL3590S.**

EFFECTIVE AND TERMINATION DATES

The Master Policy on file at the school becomes effective at 12:01 a.m., August 1, 2010. Coverage becomes effective on that date or **the date application and premium is received by the Company, which ever is later.** The Master Policy terminates at 12:01 a.m., August 1, 2011 or at the end of the period through which the premium is paid. The spring/summer semester is effective 12:01 a.m. on January 24, 2011 and will terminate at 12:01 a.m. on August 1, 2011. Coverage is in effect 24 hours a day.

ELIGIBILITY

Class I: Enrolled students of the Policyholder taking 9 or more credit hours and all clinical students in nursing and other health related courses and all physical education students are automatically covered for Basic Accident Medical Expense benefits.

Class II: All International and Nursing Clinical students are automatically billed for the Basic Sickness and Supplemental Accident & Sickness Expense Benefits. Resident Hall students and students engaged in intercollegiate sports will be directed to enroll in the Basic Sickness and Supplemental Accident & Sickness Expense Benefits unless they can demonstrate that they possess other valid healthcare insurance.

If you are an **International Student** and have existing medical insurance coverage under another policy (self, parent, spouse, etc.) you may waive the coverage. The only way to waive the insurance is via the internet at <http://www.ajfusa.com>. The deadline for requesting a waiver for the Annual term is September 30, 2010.

The deadline for requesting a waiver for the Spring/Summer term is February 15, 2011.

If you are a **Nursing Clinical Student** and have existing medical insurance coverage under another policy (self, parent, spouse, etc.) you may waive the coverage. In order to waive the insurance, go to the Nursing Department Office (9-111) and provide a copy of your current insurance card. At that time you will complete a waiver form. The Student Accounts Office will then remove the health insurance fee from your bill upon receipt of this waiver. This must be done by August 15, 2010 for the Annual term January 15, 2011 for students starting the program in the spring semester.

Class III: All enrolled students of the Policyholder taking 9 or more credit hours, except International, Nursing Clinical, Resident Hall and Student-Athletes engaged in intercollegiate sports, will be given the option to purchase the Basic Sickness and Supplemental Accident & Sickness Expense Benefits.. You may enroll via the internet using the Program Administrator's website at: www.ajfusa.com. Visa, MasterCard and Discover are acceptable payment methods. The deadline to enroll online is September 30, 2010 for the annual coverage; February 15, 2011 for the Spring Term 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 Two Madison Avenue, Larchmont, NY, 10538. *Please note any enrollments submitted after the enrollment deadline date will be covered from the date after the Plan Administrator receives both the application and premium. **Premiums will not be pro-rated.**

Class IV: All Part-time students taking 6 or more credit hours will be given the option to purchase the Basic and Supplemental Accident & Sickness Medical Expense benefits. You may enroll via the internet using the Program Administrator's website at: www.ajfusa.com. Visa, MasterCard and Discover are acceptable payment methods. The deadline to enroll online is September 30, 2010 for the annual coverage; February 15, 2011 for the Spring Term 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 Two Madison Avenue, Larchmont, NY, 10538. *Please note any enrollments submitted after the enrollment deadline date 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 are eligible to enroll after the open enrollment period only if they lose coverage under their parent's plan or employer plan. The student will have to enroll within 63 days in order to avoid a break in coverage (see Pre-existing Condition Limitation in the brochure). Proof of such loss of coverage should be submitted to the Claims Administrator Klais & Company, Inc at the time of submission of your first claim. If you wish to purchase this benefit, please follow the Enrollment Instructions below. **Premiums will not be pro-rated.**

IDENTIFICATION CARDS

Student Identification Cards for Students of Monroe Community College will be available on-line at www.ajfusa.com.

PREMIUM SCHEDULE

Class II:

Annual: \$475.00

Spring: \$310.00

Class III:

Annual: \$1,108.00

Spring: \$720.00

Class IV:

Annual: \$1,275.00

Spring: \$744.00

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

Accident means an event which (a) causes Injury to one or more Covered Persons; and (b) occurs while coverage is in effect for the Covered Person.

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 reasonable 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.

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

Usual, Reasonable and Customary Expense means

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

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

We, Us or Our means United States Fire Insurance Company

You, Your or Yours means the Insured Student.

PREFERRED PROVIDER NETWORK

Utilizing the Beechstreet or the MultiPlan Nationwide Preferred Provider Networks may decrease your out of pocket costs under this Accident and Sickness Insurance Plan. The Beechstreet and MultiPlan Networks consists of hospitals, physicians and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. You are not required to utilize a Beechstreet 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.

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

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

EXTENSION OF BENEFITS

Coverage provided under this policy ends on the policy expiration date unless the insured person is under the care of a physician for a covered condition. For students under the care of a physician on the expiration date of the policy, benefits will be extended for up to 12 months after the expiration date. The extension of coverage only applies to insured persons who are not eligible to continue coverage under the new or renewal policy issued to the Policyholder. All benefits paid are subject to the policy maximum.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH & DISMEMBERMENT EXPENSE BENEFITS
--

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

<u>For Loss of:</u>	<u>Amount</u>
Life	\$5,000
Two hands, two feet, or sight of two eyes	\$5,000
One hand and one foot	\$5,000
One hand and the sight of one eye	\$5,000
One foot and the sight of one eye	\$5,000
One hand or one foot or sight of one eye	\$2,500

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.

**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 up to a Per Condition Aggregate Maximum of \$6,000.00 per Injury. The following Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthesiologist; (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.

Accidents that are the result of Intercollegiate Sports are covered up to a maximum of \$1,000 per 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 \$10,000 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 Semi-Private Rate.

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 \$750.00. Such Expenses include (a) operating, delivery and treatment rooms and equipment; (b) diagnostic x-ray and laboratory tests; (c) lab studies; (d) oxygen tent; (e) blood and blood services; (f) prescribed drugs and medicines; (g) medical and surgical dressings, supplies, casts and splints; (h) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;

(i) chemotherapy treatment with radioactive substances; (j) intravenous injections and solutions, and their administration; (k) physical and occupational therapy; and (l) other necessary and prescribed hospital expenses.

Surgical Expense Benefit (Inpatient): We will pay up to \$6,000 of the Usual Reasonable and Customary Charges incurred for surgery performed by a licensed Doctor.

Anesthetist Expense Benefit: We will pay up to \$1,500 of the Usual Reasonable and Customary Charges for the services of an anesthetist.

Assistant Surgeon Benefit: We will pay up to \$1,200 of the Usual Reasonable and Customary Charges for the services of an assistant surgeon.

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 \$50.00 per visit, limited to one visit per day, to a maximum 30 visits.

Outpatient Doctor Visit Expense Benefit: If an Insured Person requires the services of a Doctor, We will pay the Covered Charges incurred up to \$75.00 per visit, beginning with the 2nd visit, limited to one visit per day, to a maximum of 15. Treatment received at the Health Center or receives a referral will be considered as the first visit.

Sickness Dental Expense: If a Covered Person requires treatment for impacted wisdom teeth or dental abscesses, We will pay the covered Expense incurred up to a maximum of \$100.00 per tooth.

Emergency Room Expense Benefit: If an insured Person requires the use of an emergency room including x-ray and laboratory services; the We will pay up to a maximum of \$300 per Sickness.

Outpatient Diagnostic X-ray & Laboratory Expense Benefit: If an Insured Person is prescribed by an attending Doctor for diagnostic x-ray services on an outpatient basis, benefits will be paid to a maximum of

\$400.00. Benefits include coverage for mammographic examination and cytological screening (Pap smear).

Outpatient Prescription Drug Expense Benefit: If an Insured Person requires a prescription drug prescribed by a doctor; We will pay 80% for generic or 50% for a brand name drug (per prescription), up to a \$250.00 per policy year maximum, limited to a 30 day supply per prescription at a time.

Ambulance Expense Benefit: If an Insured Person requires the need of an ambulance, we will pay a maximum benefit of \$500.00 per Sickness.

Consultant Expense Benefit: If an Insured Person requires the services of a Consultant, We will pay a maximum benefit of \$50.00 per Sickness.

<p style="text-align: center;">SUPPLEMENTAL ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS</p>

If Covered Expenses exceed the maximum the Company owes under the Basic Accident or Basic Sickness benefits, the Company will pay 80% of Eligible Expenses up to a maximum of \$50,000. The most the Company will pay for any one Accident or Illness is \$50,000. Hospital Room & Board expenses will not be more than the usual semi-private room charge.

<p style="text-align: center;">TRAVEL ASSIST PROGRAM Class II, Class III & Class IV Only</p>

“Fairmont Specialty Travel Assistance Program”

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 services include: Emergency Evacuation, Medically Necessary Repatriation, Repatriation of Remains, Family or 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

ADDITIONAL BENEFITS

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 25 visits of active treatment per policy year for outpatient care in a facility issued an operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a psychiatrist or psychologist, or a professional corporation or university faculty practice corporation.

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

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

Definitions:

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

“Biologically based mental illness” means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that

substantially limits the functioning of the person with the illness. Under the law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

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

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

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

Exceptions to Coverage:

Benefits do not apply to:

1. individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services;
2. services solely because such services are ordered by a court; or

3. services determined to be cosmetic on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

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

Inpatient Chemical Abuse and Chemical Dependence Expense Benefit: If on account of Chemical Abuse or Chemical Dependence, an Insured Person requires inpatient treatment, We will pay for such treatment as follows:

When the Insured Person is confined as an inpatient in a Hospital or a Detoxification Facility, We will pay benefits for detoxification on the same basis as any other Sickness. But, We will not cover more than seven (7) days of active treatment in any one calendar year. When the Insured Person is confined in a hospital or Chemical Abuse Treatment Facility, We will pay benefits for rehabilitation services on the same basis as any other Sickness. But, We will not cover more than thirty (30) days of inpatient care for such services in any one calendar year.

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

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

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

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

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

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

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

Cancer Second Opinion Expense Benefit: We cover charges for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. If this Plan requires the use of Network Providers, the Insured Person is entitled to a second medical opinion from a non-participating specialist, at no additional cost beyond that which the Insured Person would have paid for services from a participating specialist, provided the Insured Person's attending Doctor provides a written referral. A second medical opinion provided by a non-participating specialist absent a written referral will be covered subject to the payment of additional coinsurance. We treat such charges the same way We treat Covered Charges for any other Sickness.

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

determined by the Insured Person's Doctor to be medically appropriate.

We also cover charges for breast reconstruction surgery after a mastectomy including: (a) all stages of reconstruction of the breast on which the mastectomy has been performed; and (b) surgery and reconstruction of the other breast to produce symmetry. Surgery and reconstruction will be provided in a manner determined by the attending Doctor and the Insured Person to be appropriate. We treat such charges the same way We treat any other Covered Charges for any other Sickness.

Diagnostic Screening For Prostatic Cancer Expense

Benefit: We cover charges for Diagnostic Screening for Prostatic Cancer as follows: (a) standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and (b) an annual standard diagnostic examination including, but not limited to, a digital rectal examination prostate-specific antigen test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors. We treat such charges the same way We treat Covered Charges for any other Sickness.

Diabetes Treatment Expense Benefit: We cover charges for the following Medically Necessary diabetes equipment services and supplies for the treatment of diabetes, when recommended by a Doctor or other licensed health care provider. We treat such charges the same way We treat any other Covered Charges for a Sickness. Such supplies include: blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar.

We also cover charges for expenses incurred for diabetes self-management education. Coverage for self-management education and education relating to diet shall be limited to Medically Necessary visits upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Insured Person's symptoms or

conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Doctor or other licensed healthcare provider, the Doctor's office staff, as part of an office visit, or by a certified diabetes nurse educator, certified nutritionist, certified dietician registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

Enteral Formulas Expense Benefit: We will pay for an Insured Person's Covered Charges for enteral formulas when prescribed by a Doctor or licensed health care provider. The prescribing Doctor or health care provider must issue a written order stating that the enteral formula is Medically Necessary and has been proven as a disease-specific treatment for those individuals who are or will become malnourished or suffer from disorders, which if left untreated will cause chronic physical disability, mental retardation or death.

We cover enteral formulas and food products required for persons with inherited diseases of amino acid and organic acid metabolism, Crohn's Disease, gastroesophageal reflux with failure to thrive, disorders of the gastrointestinal motility such a chronic intestinal pseudo-obstruction and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. We also cover modified solid food products that are low protein or which contain Medically Necessary modified protein in an amount not to exceed \$2,500 per calendar year or for any continuous period of twelve months. We treat such charges the same way we treat Covered Charges for any other Sickness.

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

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a healthcare facility. Covered

services may be provided by a certified-nurse midwife, under qualified medical direction, affiliated or practicing in conjunction with a licensed facility, unless the attending Doctor, in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If so, We will cover charges for one home health care visit. The visit must be requested within 48 hours of the delivery (96 hours in the case of a cesarean section) and the services must be delivered within 24 hours: (a) after discharge; or b) of the time of the mother's request, whichever is later. Charges for the home health care visit are not subject to any deductible, coinsurance or co-payments. Covered Charges include at least two payments, at reasonable intervals, for prenatal care and one payment for delivery and postnatal care provided. We also cover charges for parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments. Newborn infant care is covered when the infant is confined in the hospital and has received continuous hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, except circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

End of Life Care Expense Benefit: If an Insured Person is diagnosed with Advanced Cancer, We will cover services provided by a facility or program specializing in the treatment of terminally ill patients if the Insured Person's attending health care practitioner, in consultation with the medical director of the facility or program determines that the Insured Person's care would appropriately be provided by such a facility or program.

If we disagree with the admission of the Insured Person into the facility, or the provision or continuation of care by the facility, We will initiate an expedited external appeal. Until a decision is rendered, We will continue to provide coverage for care provided in the facility. The decision of the external appeal agent will be binding on both Us and the Insured Person.

"Advanced Cancer" means a diagnosis of cancer by the Insured Person's attending health care practitioner certifying that there is no hope of reversal of primary disease and that the person has fewer than sixty days to live. We treat such charges the same way we treat Covered Charges for any other Sickness.

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

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

Early Intervention Services Benefit: Benefits will be payable for Early Intervention Services for children up to three years of age who are disabled or at risk of disability on the same basis as any other Sickness.

Benefits paid for Early Intervention will not decrease benefits payable for other conditions.

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

EXCLUSIONS

The Plan does not cover nor provide benefits for:

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

follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.

12. 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. Treatment of mental or nervous disorders except as specifically provided.
14. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile.
15. Routine physical, preventive medicines, serums, or vaccines, unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Plan.
16. Injury or Sickness caused by, contributed to or resulting from being intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.
17. Accident treatment arising out of Intercollegiate Sports in excess of **\$1,000**.

PRE-EXISTING CONDITIONS LIMITATION

A "Pre-existing Condition" is a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Doctor during the 6 consecutive months prior to the effective date of the Insured Person's coverage under this Plan.

The Pre-existing Condition Waiting Period is 12 months. Coverage will not be provided for a Pre-existing Condition until the Waiting Period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under this Plan and begins on the Insured Person's effective date. If the Insured Person receives treatment for a service for a Pre-existing Condition: (a) We will not pay benefits for a such condition until: the day after a 12 consecutive month period has passed from the Insured Person's effective date; (b) with respect to a pregnancy, the day after a 10 consecutive month period has passed from the Insured Person's effective date; and (c) We will pay only for Loss or Expense incurred after such 12 consecutive month period or ten (10) consecutive months with respect to pregnancy. A period of Creditable Coverage will be credited if the

previous Creditable Coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Payment will be in accordance with the provisions of this Plan.

Exceptions: The Pre-existing Conditions exclusion does not apply to any of the following: (a) genetic information, in the absence of a diagnosis of a condition related to such information; (b) a covered newborn dependent child who, as of the last day of the 31-day period beginning with the date of birth, is covered under Creditable Coverage; or (c) a covered adopted dependent child under the age of 18, who, as of the last day of the 31-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage.

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 Monroe Community College.

CLAIM PROCEDURES

In the event of an Injury or Sickness:

1. An Insured Student should report at once to the Student Health Center for treatment or advice
2. A Company claim form is required for filing a claim. Claim forms are available from the Student Health Center also at www.ajfusa.com

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

- Completed claim form including Insured's name, address, student identification number, and the name of the University under which the student is insured.
 - All itemized medical and hospital bills.
 - Prescription Drug bills (not cash register receipts) showing prescription number, name of drug, date prescribed and name of person for whom the drug was prescribed..
3. 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
EDI Payer # 34145

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.