

LIMITED BENEFITS HEALTH INSURANCE

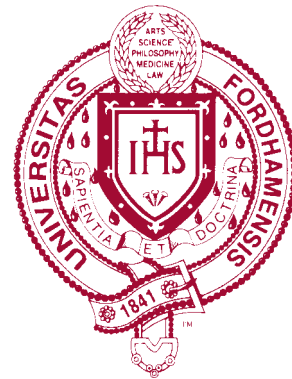
The insurance evidenced in this brochure provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical insurance, Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance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

The Insurer suggests that you retain this brochure so you will have a ready reference to the benefits of the Plan.

Any provision of the Policy or the brochure, which is in conflict with the statutes of the state in which the Policy is issued will be administered to conform with the requirements of such state statutes.

Under HIPAA's Privacy Rule the Insurer is required to provide you with notice of the Insurer's legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your insurance identification card. If, at anytime, you wish to request a copy of Combined Life Insurance Company of New York's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640 Attn: HIPAA Privacy Office, call 1-800-951-6206, select HIPAA or online at <http://www.combinedinsurance.com/customer-center/hipaa-insurance.html>.

STUDENT ACCIDENT & SICKNESS INSURANCE



FORDHAM
UNIVERSITY

Rose Hill Campus, Bronx, New York 10458

Lincoln Center Campus, New York, New York 10023

Westchester Campus, West Harrison, New York 10604

2009-2010

Underwritten By

Combined Life Insurance Company of New York

Policy Number: CUH201731

IMPORTANT NUMBERS

THE SINGLE SOURCE FOR ALL OF YOUR INQUIRIES

▶ GENERAL INSURANCE QUESTIONS



172 Bechtel Road, Collegeville, PA 19426

Phone.....800-322-9901

Fax.....610-489-9325

Website.....www.cirstudenthealth.com/fordham

DIRECT CONTACT INFORMATION

- **University Student Health Services**.....718-817-4160

- **CLAIM ADMINISTRATOR**

For claim and benefit questions and online claim status:

Administrative Concepts, Inc.

994 Old Eagle School Road, Suite 1005

Wayne, PA 19087-1802

Phone.....888-293-9229

Website.....www.visit-aci.com

- **PARTICIPATING PROVIDERS**



.....800-432-1776

Monday through Friday.....8:00 a.m. to 8:00 p.m.

Website.....www.beechstreet.com

- **PARTICIPATING PHARMACIES**

For pharmacy locations after you receive your insurance ID card. This number is effective for enrolled members only. You will need the Group Number and Member Number printed on your insurance ID card.

medco.....800-400-0136

Website.....www.medco.com

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INTRODUCTION

This brochure is a brief description of the Student Accident and Sickness Insurance Plan for students at Fordham University. The exact provisions governing this insurance are contained in the Master Policy issued to the University. The Master Policy shall control in the event of any conflict between the Policy and this brochure. Coverage is valid 24 hours a day worldwide.

POLICY TERM

Coverage begins at 12:01 AM August 23, 2009 (or the day after the postmark date of premium payment, whichever is later) and continues until 12:01 AM on August 23, 2010. The last date for enrollment for Fall Semester is October 13, 2009, for Spring Semester is February 26, 2010, and for Summer Semester is June 23, 2010.

COST OF INSURANCE

The annual cost for the Student Accident and Sickness Insurance Plan is:

	<u>8/23/2009 to 8/23/2010</u>
Student	\$1,620.00
Additional for Spouse	\$1,897.00
Additional for Child (Each)	\$1,083.00

ELIGIBILITY

▶ **ACCIDENT MEDICAL EXPENSE BENEFIT**

I. Accident Medical Expense Benefit

A registered student of the University is automatically provided Accident Medical Expense coverage for the semester (Fall and/or Spring) for which he/she is attending classes.

Coverage begins at 12:01 AM on August 23, 2009, and continues until 12:01 AM on August 23, 2010. Coverage ends at 12:01 AM on January 1, 2010, for those students not returning for Spring Semester.

A registered student who enters Fordham for the first time for Summer Semester 2010 is not automatically provided Accident Medical Expense coverage. Please see SUMMER SEMESTER section.

▶ **OPTIONAL MEDICAL EXPENSE BENEFITS**

To purchase the Optional Sickness and Supplemental Medical Expense Benefit and Enhanced Supplemental Medical Expense Benefit follow the instructions online at www.Fordham.edu/health.

■ **Optional Upgrade**

II. Sickness Medical Expense and

III. Supplemental Medical Expense

Optional Sickness Medical Expense and Supplemental Medical Expense benefits are available to eligible students at an annual premium of \$1,620.

■ **Additional Optional Upgrade**

IV. Enhanced Supplemental Medical Expense

Enhanced Supplemental Medical Expense benefits may be added to Sections I, II, and III for an additional annual premium of \$266 (for a total annual premium of \$1,886).

Only those enrolled in the Sickness Medical Expense and Supplemental Medical Expense benefits may add the Enhanced Supplemental Medical Expense benefit.

▶ **SUMMER SEMESTER**

A registered student who enters Fordham for the first time for Summer Semester 2010 may purchase the Fordham University Student Accident and Sickness Insurance plan. Enrollment Forms are available from Collegiate Insurance Resources. Coverage for summer semester begins at 12:01 AM on May 23, 2010, or the day after premium payment, whichever is later, and continues until 12:01 AM on August 23, 2010.

DEPENDENTS

Students enrolled in the Student Accident and Sickness Insurance Plan may also enroll their dependent children (up to and including 19 years) or spouses who reside with the Insured Student. Dependents must enroll by October 13, 2009 for Fall Semester, February 26, 2010 for Spring Semester, and June 23, 2010 for Summer Semester.

- ▶ **Newborn Coverage** - Coverage for newborn children will consist of coverage for Accident or Sickness (if the student is covered for Sickness), including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent child coverage when the child is born. If the Insured Student does not have dependent child coverage when the child is born, the Insurer covers the newborn child for dependent benefits for the first 31 days from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits for the first 31 days from and after the moment the child is placed in the physical custody of the Insured Student for adoption.

To continue the newborn child's dependent benefits past the first 31 days, the Insured Student must complete the Enrollment Form and pay the necessary premium within 31 days of the child's birth. Contact Collegiate Insurance Resources for an Enrollment Form and pro-rated rates.

OTHER COVERAGE OPTIONS

Insured Students (and their Insured Dependents) who are not eligible to re-enroll in the Student Accident and Sickness Insurance Plan after coverage expires should contact Collegiate Insurance Resources for possible options. The election to purchase other coverage must be made prior to the expiration date under the Student Insurance Plan.

Students in need of specialized coverage (International Travel, Dental, Eye Care or Personal Property Coverage) should contact Collegiate Insurance Resources for possible options.

ENROLLMENT PERIOD

Students and their eligible dependents wishing to purchase the optional sickness benefits must enroll during the open enrollment period at the beginning of the Fall Semester. The Spring and Summer Semester open enrollment periods are available only for new students (and their eligible dependents) first entering the University for the Spring or Summer Semester.

Late enrollment is considered only if a change has occurred in your insured status regarding coverage that was in-force during the open enrollment period. Late enrollment must be completed within 30 days of the termination of other coverage. Contact Collegiate Insurance Resources for rates and forms.

PREMIUM REFUND POLICY

Except for medical withdrawal due to a covered injury or sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the policy and a full refund of the premium may be made. Students withdrawing after such 31 days will remain covered under the policy for the full period for which premium has been paid and no refund will be available.

TERMINATION OF INSURANCE

I. Accident Medical Expense Benefit

Benefits are payable under the Accident Medical Expense Benefit of this Plan for those Covered Medical Expenses commencing while insured, resulting from an accident occurring during the term insured, and incurred within 52 weeks from the date of the accident.

II. Sickness Medical Expense, and

III. Supplemental Medical Expense, and

IV. Enhanced Supplemental Medical Expense

Benefits are payable under the optional Sickness, Supplemental, and Enhanced Supplemental Medical Expense Benefits of this Plan only for those expenses incurred while this Plan is in effect as to the Insured Person. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits.

EXTENSION OF BENEFITS

If an Insured Person is confined to a hospital on the day his or her insurance terminates, expenses incurred after such termination date and during the continuance of that hospital confinement shall be payable in accordance with this Plan, but only for expenses incurred during the 31 day period following such termination of insurance.

PRE-EXISTING CONDITION

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 Doctor during the six consecutive months prior to the effective date of the Insured Person's coverage under this Plan.

The Pre-existing Condition Waiting Period is twelve 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 an Insured Person receives treatment or service for a Pre-existing Condition: (a) the Insurer will not pay benefits for such condition until the day after a twelve consecutive month period has passed from the Insured Student's effective date; (b) with respect to a pregnancy, the day after a ten consecutive month period has passed from the Insured Person's effective date; and (c) the Insurer will pay only for Loss or Expense incurred after such twelve consecutive month period or ten (10) consecutive month period 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 accord with the provisions of this Plan. If the Insured Person has a lapse in coverage exceeding 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

■ Creditable Coverage

This term means the following coverage an Insured Person had prior to the Effective Date under this Plan: (a) a group health plan; (b) health insurance or Health Maintenance Organization coverage; (c) Medicare; (d) Medicaid; (e) Military health care; (f) a medical care program of the Indian Health Services or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under the Federal Employee Health Benefits Program; (i) a public health plan as defined under Federal regulations; (j) a health benefit plan under Section 5 of the Peace Corps Act (e); or (k) any other similar coverage permitted under State/Federal law or regulations.

■ 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 30-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 30-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage.

DEFINITIONS

Autism Spectrum Disorder means a neurobiological condition that includes autism, asperger syndrome, rett's syndrome or pervasive development disorder.

Biologically Based Mental Illness means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia.

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; and (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while the Policy is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

Injury means bodily injury caused by an accident, which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Elective Treatment means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast implants; breast reduction; voluntary sterilization procedure or any sterilization reversal process; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; treatment for weight reduction; treatment of temporomandibular joint dysfunction and associated myofascial pain; radial keratotomy; learning disabilities or disorders or Attention Deficit Disorder; immunizations; treatment of infertility and routine physical examinations.

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

Insurer means Combined Life Insurance Company of New York.

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

Medical Emergency means the sudden onset of an Injury or Sickness which arises out of a medical or behavioral condition 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: (a) placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

Medically Necessary means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply shall be considered "needed" if it: (a) is ordered by a licensed Doctor; and (b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it was ordered. A service, drug or supply shall not be considered as Medically Necessary if it is investigational, experimental or educational.

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.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Charges.

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for medically necessary services and supplies required for treatment of cases of comparable severity and nature.

Serious Emotional Disturbances of a Child means a diagnosis of attention deficit disorder, disruptive behavior disorder or pervasive development disorder, and where one or more of the following: (a) serious suicidal symptoms or other life threatening self destructive behaviors; (b) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); (c) behavior caused by emotional disturbances that placed the child at risk of causing permanent injury or significant property damage; or (d) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household for a person under the age of eighteen years.

Sickness means sickness or disease, which is the sole cause of the Loss. Sickness includes both normal pregnancy and complications of pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

You, Your or Yours means the Insured Student.

BEECH STREET NETWORK



Please see Important Numbers section.

Persons insured under this plan may choose to be treated within or outside of the Beech Street Network. Beech Street consists of hospitals, physicians, and other health care providers organized into a network for the purpose of delivering quality health care at affordable rates. As part of the student health insurance program, an arrangement has been negotiated with the Beech Street Network to treat insured students for a reduced fee over the customary fees of non-Network Providers. Reimbursement rates will vary according to the source of care as described under the Plan Summary herein.

In order to use the services of a participating provider, you must present an Identification Card which is provided to all students insured under the plan.

Assignment of a network physician does not guarantee eligibility or right to student health benefits. Providers may be periodically added or deleted as participants in the provider organization. **It is the insured's responsibility to verify that a provider is a Participating Provider prior to services being rendered.**

A list of participants can be reviewed at the Student Health Center or at: www.BeechStreet.com

OUTPATIENT PRESCRIPTION DRUGS



Please see Important Numbers section.

Automatically included for students covered under the OPTIONAL BENEFITS.

After a co-payment of \$5 for generic or \$10 for a brand name drug (per prescription), the cost of prescription drugs is payable in full, up to \$1,250 for the policy year under the Sickness Medical Expense benefit.

Prescriptions must be filled at a Medco Participating Pharmacy. Insured Persons will be given an insurance ID card to show to the pharmacy as proof of coverage. A list of participating pharmacies is available at the Rose Hill Campus Student Health Center, Student Activities Office at Lincoln Center, #201 North Hall and the Wellness Center at Marymount, or by calling Collegiate Insurance Resources at 1-800-322-9901.

Before you receive your insurance ID card, if you need to have a prescription filled, go to any pharmacy, pay for the medication in full and save the receipt. Your insurance ID card will include instructions on how to file for reimbursement for prescriptions filled before you received your card. Reimbursement will be at the Medco contracted discount rate and will be less than the rate charged by the pharmacy. Not all medications are covered. Before you receive your insurance ID card you may contact Collegiate Insurance Resources for a list of covered medications or exclusions.

After you receive your insurance ID card, no claim forms need to be completed. After you receive the card you may call the toll-free customer service number listed on your card for assistance with pharmacy locations (1-800-400-0136). This number is effective for enrolled members only. You will need the Group Number and Member Number printed on your insurance ID card.

Home Delivery Pharmacy Service is available for medication taken to treat ongoing health conditions. Instructions on how to order will be included with your insurance ID card.

PLAN SUMMARY (ACCIDENT ONLY)

I. Accident Medical Expense Benefit

WHO IS COVERED?

A registered student of the University is automatically provided Accident Medical Expense coverage for the semester (Fall and/or Spring) for which he/she is attending classes.

A registered student who enters Fordham for the first time for Summer Semester 2010 is not automatically provided Accident Medical Expense coverage. Please see SUMMER SEMESTER section on page 4.

	BENEFIT IN BEECH STREET NETWORK	BENEFIT OUT OF BEECH STREET NETWORK	MAXIMUM POLICY BENEFIT
Benefit Per Injury	100%	100%	\$2,500
Deductible Per Injury	\$0	\$0	

COVERAGE

When Injury requires treatment, payment will be made for Covered Medical Expenses commencing while insured and resulting from an accident occurring during the term insured.

Covered Medical Expenses are those expenses for physicians and surgeons, hospital confinements, x-rays, lab tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other usual and customary medical expenses commencing while insured and incurred within 52 weeks from the date of the accident.

The covered expenses incurred will be payable at 100% for accidents under the basic accident benefit and no deductible will be applied.

The maximum benefit is \$2,500 for each accident. Expense in excess of \$2,500 is considered under the Supplemental Medical Expense benefit if optional benefits are purchased.

PLAN SUMMARY - CONTINUED (OPTIONAL BENEFITS)

These optional benefits may be added to the Base Accident Medical Expense Benefit by paying additional premium.

Covered Medical Expenses are those expenses for: (a) hospital room and board; (b) hospital miscellaneous; (c) inpatient and outpatient surgery; (d) anesthesia; (e) assistant surgeon; (f) inpatient and outpatient Doctor visits; (g) emergency room; (h) hospital outpatient department; (i) consultant visit; (j) licensed nurse; (k) inpatient prescription drug; (l) ambulance; and (m) other Reasonable and Customary medical expenses incurred for the treatment of an Injury or Sickness.

COVERAGE	Benefit In Beech Street Network	Benefit Out of Beech Street Network	Maximum Policy Benefit
II. Sickness Medical Expense			
BenefitPer Sickness	85%	50%	\$ 2,500
DeductiblePer Sickness	\$100	\$100	
Co-PaymentPer Outpatient Physician's Visit.....	\$ 10	\$ 20	

When an insured Person uses the services of a Beech Street provider, the covered expenses incurred will be payable at 85%, of the Preferred Allowance, subject to a \$100 deductible, per condition. When treatment is rendered by providers outside the Beech Street Network, expenses will be payable at 50% of Reasonable and Customary charges, subject to a \$100 deductible, per condition. The maximum benefit is \$2,500 for each sickness. Expense in excess of \$2,500 is considered under the Supplemental Medical Expense benefit.

III. Supplemental Medical Expense

BenefitPer Sickness	85%	50%	\$100,000
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Payment will be made for Covered Medical Expense incurred in excess of \$2,500 for each covered accident or sickness up to a maximum of an additional \$97,500 payable under this benefit for each accident or sickness. When an insured Person uses the services of a Beech Street provider, the covered expenses incurred will be payable at 85% of the Preferred Allowance of the covered charges. When treatment is rendered by providers outside the Beech Street Network, expenses will be payable at 50% of Reasonable and Customary charges.

The Enhanced Supplemental Medical Benefit may be added by paying an additional premium.

			Lifetime Maximum Benefit
IV. Enhanced Supplemental Medical Expense Benefit			
BenefitAll-cause Lifetime Maximum	90%	75%	\$250,000*

Payment will be made for Covered Medical Expense incurred **in excess of \$100,000** for each covered accident or sickness up to a maximum of an additional \$150,000 payable under this benefit for all conditions combined.

When an insured Person uses the services of a Beech Street provider, the covered expenses incurred will be payable at 90% of the Preferred Allowance. When treatment is rendered by providers outside the Beech Street Network, expenses will be payable at 75% of Reasonable and Customary charges.

COVERED MEDICAL EXPENSES

The following are subject to the benefit limits described in this brochure.

Autism Spectrum Disorder Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred by an Insured Person for diagnosis or treatment of Autism Spectrum Disorder. Diagnosis or treatment for medical services, drugs, and supplies must be Medically Necessary and prescribed by a Doctor. We cover such charges the same way We treat covered charges for any other sickness.

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

Cancer-Second Opinion Expense Benefit: The Insurer covers 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 is entitled to a second medical opinion from a non-participating specialist, at no additional cost beyond that which the Insured would have paid for services from a participating specialist, provided the Insured'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. The Insurer treats such charges the same way the Insurer treats Covered Charges for any other Sickness.

Chemical Abuse and Chemical Dependence Outpatient Expense Benefit: When the Insured Person is not hospital confined as an inpatient, the Insurer will pay for diagnosis and treatment of Chemical Abuse and Chemical Dependence on the same basis as any other Sickness. But the Insurer will not cover more than 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 Abuse and Chemical Dependence provided that the total number of such visits, when combined with those of the Insured Person in need of treatment, do not exceed 60 outpatient visits in any one calendar year, and provided further that the 60 visits shall be reduced only by the number of visits actually utilized by the covered family members. The Insurer treats such charges in the same way the Insurer treats 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.

Chiropractic Care Expense Benefit: The Insurer 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. The Insurer treats such charges the same way the Insurer treats Covered Charges for any other Sickness.

Consultant Expense: If an Insured Person requires the services of a Consultant or Specialist when it is deemed necessary and ordered by the attending Doctor for the purpose of confirming or determining a diagnosis, but not for treatment, the Insurer will pay benefits for the Covered Charges incurred.

Contraceptive Services Expense Benefit: The Insurer is required by law to offer this coverage and 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. (Questions concerning these benefits should be addressed to the Insurer's Third Party Administrator, Administrative Concepts, Inc.)

Cytological Screening Expense Benefit: The Insurer covers charges for Expenses incurred for an annual Cytological Screening (Pap Smear) for cervical cancer for women eighteen and older. The Insurer covers such charges the same way the Insurer treats Covered Charges for any other Sickness. Cytological 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.

Dental Sickness Expense: The Insurer will pay up to \$50 per tooth for treatment of dental abscesses or for surgical removal of impacted wisdom teeth. No other policy benefits are payable.

Diabetes Treatment Expense Benefit: The Insurer covers 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. The Insurer treats such charges the same way the Insurer treats 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. The Insurer also covers charges for expenses incurred for diabetes self-management education. Coverage for self-management education and education relating to diet shall be limited to medically necessary visits upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Insured Person's symptoms or conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Doctor or other licensed healthcare provider; the Doctor's office staff, as part of an office visit; or by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

Diagnostic Screening for Prostate Cancer Expense Benefit: The Insurer covers charges for Diagnostic Screening for Prostate 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. The Insurer treats such charges the same way the Insurer treats Covered Charges for any other Sickness.

Doctor Expense: If an Insured Person requires the services of a Doctor both in and out of the hospital, for non-surgical services, the Insurer will pay the Covered Charges incurred, limited to one visit per day.

Early Intervention Services: We cover charges for Medically Necessary Early Intervention Services, We will pay the Covered

Percentage of the Covered Charges incurred up to a maximum of \$1,000 per policy year and an Early Intervention Services Benefit maximum of \$10,000. Visits used for Early Intervention Services shall not reduce the number of visits otherwise available under the policy.

Eating Disorders: If an Insured Person requires treatment for an Eating Disorder Condition such as: binge eating disorder including anorexia nervosa, and bulimia nervosa, and treatment has been provided by a state identified Eating Disorder Center or a Comprehensive Health Care Center, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such treatment. Covered treatment includes psychological services, and inpatient medical and surgical treatment. We cover such charges the same way We treat covered Charges for any other Sickness.

Emergency Room Expense: If an Insured Person requires the use of an emergency room, as a result of a Medical Emergency, the Insurer will pay the Covered Charges incurred.

End of Life Care Expense Benefit: If an Insured Person is diagnosed with Advanced Cancer, the Insurer 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 the Insurer disagrees with the admission of the Insured Person into the facility, or the provision or continuation of care by the facility, The Insurer will initiate an expedited external appeal. Until a decision is rendered, the Insurer will continue to provide coverage for care provided in the facility. The decision of the external appeal agent will be binding on both the Insurer 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. The Insurer covers such charges the same way the Insurer treats Covered Charges for any other Sickness.

Enteral Formulas Expense Benefit: The Insurer 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. The Insurer covers enteral formulas and food products required for persons with inherited diseases of amino acid and organic acid metabolism, Crohn's Disease, gastroesophageal reflux with failure to thrive, disorders of the gastrointestinal motility such as chronic intestinal pseudo-obstruction and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. The Insurer also covers 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. The Insurer treats such charges the same way the Insurer treats Covered Charges for any other Sickness.

Hospital Confinement, Mental, Nervous or Emotional Inpatient Expense Benefit: 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 Charges 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.

Hospital Room and Board Expense: If an Insured Person requires confinement in a hospital, the Insurer will pay the Covered Charges incurred up to the daily semi-private room rate.

Mammography Examination Expense Benefit: The Insurer 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. The Insurer covers such charges the same way the Insurer treats Covered Charges for any other Sickness.

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

The Insurer covers charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for an Insured Person and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If so, The Insurer 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 the delivery and postnatal care provided. The Insurer also covers charges for parent education, assistance and training in breast or bottle-feeding and the performance of any necessary maternal and newborn clinical assessments. 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. The Insurer covers such charges the same way the Insurer treats Covered Charges for any other Sickness.

- ▶ **Newborn Infant Care:** 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.

Mental Illness, Biologically Based (Adults and Children) and Serious Emotional Disturbances of Children Expense Benefit: If an Insured Person requires treatment for Biologically Based Mental Illness, We will pay for such treatment of a person of any age and for Serious Emotional Disturbances of a Child under the same terms and conditions applied to other medical conditions.

The benefits shall include the following: (a) inpatient Hospital services; (b) outpatient services; (c) prescription drugs, if this Policy includes the Prescription Drug Expense Benefit.

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

Mental, Nervous or Emotional Outpatient Expense Benefit: When an Insured Person is not so Hospital confined, We will pay the Covered Percentage of the Covered Charges incurred for 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 Doctor 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.

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

Miscellaneous Outpatient Expense: If an Insured Person incurs expenses for the cost of diagnostic x-rays, laboratory tests, acupuncture, and other reasonable expenses for services or supplies, necessary for treatment of the Injury or Sickness as required by the attending Doctor for which no other policy benefits are payable, the Insurer will pay the Covered Charges incurred.

Nurse Expense: If an Insured Person requires the service of a licensed nurse or licensed practical nurse during a Hospital Confinement, the Insurer will pay the Covered Charges incurred.

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

As used in this provision, Pre-Hospital Medical Emergency Services means the prompt evaluation and treatment of a medical emergency condition, and/or non-airborne transportation of an Insured Person to a Hospital. Reimbursement for non-airborne transportation will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person.

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

Reconstructive Breast Surgery Expense Benefit: The Insurer covers 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. The Insurer also covers 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. The Insurer treats such charge the same way the Insurer treats Covered Charges for any other Sickness.

Second Surgical Opinion Consultation Expense: The insurer will pay the Covered Percentage of the Covered Charges for a second opinion consultation by a Board certified specialist in the medical field relating to the surgical procedure to be performed.

Surgical Expense: The Insurer will pay the Covered Charges incurred for surgery performed by a licensed Doctor (In or Out of the Hospital) and expenses in connection with a surgery when the Insured Person requires the services of an anesthetist or assistant surgeon. Benefits will be paid in accordance with the MDR Schedule (Medical Data Research) survey of surgical fees for Reasonable and Customary Expense.

MEDICAL EVACUATION AND TRAVEL ASSISTANCE

Travel Assistance Services are available to all students insured under the Plan. Medical Evacuation Benefits are only available to those Insured Students who purchase the OPTIONAL Medical Evacuation Benefit available by contacting Collegiate Insurance Resources.

▶ **Emergency Medical Evacuation**

We will pay for benefits for the Covered Expenses incurred, up to \$10,000 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; or (b) 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. Expenses for special transportation must be: (a) recommended by the attending Doctor; 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 Doctor.

▶ **International Assistance Program**

The International Assistance Program managed by On Call International, provides access to a 24-hour worldwide assistance network. To contact On Call International for emergency assistance anywhere in the world, simply call the assistance center collect. The multilingual staff will answer your call and provide assistance. The following services are included:

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

EXCLUSIONS

The Policy does not cover nor provide benefits for:

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. Expense incurred for services normally provided without charge by the Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by the Policyholder;
3. Expense incurred for eyeglasses, contact lenses, hearing aids or prescriptions or examinations therefore;
4. Injury due to participation in a riot;
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 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, the Insurer will refund the unearned pro-rata premium to such Insured Person;
8. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
9. Treatment provided in a governmental 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 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 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. Expense (in excess of \$200) covered by any medical, health or accident insurance provided on a group basis. This exclusion shall only apply if the entire premium for the coverage under this Plan is paid by the College, with no contributions from the Insured Student;
13. Injuries sustained as the result of a motor vehicle accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance;
14. Routine physicals, preventive medicines, serums, vaccines or immunizations, unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Plan or unless specifically provided under this Plan;
15. Pre-existing conditions as defined by this Plan.
16. Treatment of mental or nervous disorders, except as specifically provided;
17. Treatment of Chemical Abuse and Chemical Dependence, except as specifically provided;
18. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a physician; or expenses non-medical in nature;
19. Expense as a result of participation in a felony;
20. Suicide, attempted suicide or intentionally self-inflicted injury;
21. Expense incurred for: topical acne treatments, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the hospital Expense Benefit unless medically necessary;
22. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports;
23. Voluntary or elective abortion;
24. Services or supplies rendered by a close relative of the Insured Person or by a home health aide who is a member of your household. By "close relative" We mean an Insured Person's spouse, children, parents, brothers, and sisters;
25. Services not Medically Necessary;
26. An amount of a charge in excess of the Reasonable and Customary Expense;
27. 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 facility for youth operated by the Office of Children and Family Services;
28. Mental Health benefits or services solely because such services are offered by a court;
29. 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.

CLAIM PROCEDURE

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

1. Obtain a claim form from the Student Health Center, or by contacting the claim administrator, Administrative Concepts, Inc. (ACI).
2. The physicians and hospitals may submit itemized bills directly to ACI electronically using Payor # 22384 or mailing them to the address below.
3. Complete a claim form and mail it to ACI within 30 days of the date of the Injury or commencement of the Sickness, or as soon thereafter as possible. Mail the claim form to Administrative Concepts, Inc., 994 Old Eagle School Road, Suite 1005, Wayne, PA 19087-1802.
4. Claim forms are available online at www.visit-aci.com or by calling 888-293-9229. If the providers have given you bills, attach them to the claim form.
5. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to ACI. Online claim status is available at www.visit-aci.com or by calling 888-293-9229. Select option "2" for Customer Service.
6. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills received after the initial claim form has been submitted should be mailed promptly to ACI. No additional claim forms are needed as long as the Insured Person's name and identification number are included on the bill.

COORDINATION OF BENEFITS

Expenses for an Injury and for a Sickness will be paid according to the New York State Coordination of Benefits Provision as outlined in the Master Policy.

REIMBURSEMENT AND SUBROGATION

If the Insurer pays covered expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse the Insurer for the expenses paid. The Insurer may also take subrogation action directly against the third party. The Insurer's Reimbursement rights are limited by the amount You recover. The Insurer's Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist the Insurer in exercising the Insurer's rights under this provision and do nothing to prejudice the Insurer's rights.

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 Your provider would like additional information or have a complaint concerning the denial, please contact the Insurer's Third Party Administrator, Administrative Concepts, Inc. (ACI) at 888-293-9229. ACI will address concerns and attempt to resolve the complaint. If ACI is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to ACI. Please include Your name, 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. ACI will acknowledge Your appeal within 10 working days of receipt or within 72 hours if the appeal involves a life-threatening situation. A decision will be sent to You within 30 days. If there are extraordinary circumstances involved, ACI 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/extapp/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.