UNION GRADUATE COLLEGE

Student Injury and Sickness Insurance Plan

designed for

Union Graduate College 2014-2015

Schenectady, New York
Plan Number: US096494

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Before You Waive Coverage

Before you waive coverage under the Union Graduate College Student Insurance Plan, check your current plan carefully to make sure you're fully covered while on campus and throughout the academic year. Often a student covered by a Health Before Maintenance Organization (HMO) or a managed care plan at home may have limited or no benefits while in the Schenectady, NY area, other locations in the U.S., or in a foreign country. Finally, some students declare financial independence to gain eligibility for financial aid programs. This may mean that the student is ineligible for coverage as a dependent under a parent's plan regardless of the student's age.

Student Eligibility and Enrollment

All Union Graduate College students enrolled in at least 2 or more courses per trimester are automatically enrolled in and billed for the Student Health Insurance Plan. Students who have comparable coverage may waive coverage.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased to stay in effect. The Insurance Company maintains its right to investigate student status and to verify that the plan eligibility requirements have been met.

Dependent Eligibility and Enrollment

Students must purchase coverage for their eligible dependent(s) at the same time as their own initial plan enrollment. Eligible dependents are the spouse and children under 26 years of age. Dependent coverage must be purchased for the same time period as the student's period of coverage and cannot exceed coverage purchased by the student. For example, a student enrolled for annual coverage cannot purchase dependent coverage for the spring semester unless a qualifying event, as defined below, occurs.

Students can add eligible dependent(s) if they experience one of the following qualifying events: (a) marriage (b) birth of a child, (c) divorce, or (d) if the dependent is entering the country for the first time. Please note, with the exception of the dependent entering the country for the first time, all other qualifying events noted above will only be approved if experienced by the student. If dependent enrollment meets one of these qualifying events, the Dependent Enrollment Form, supporting documentation and payment must be received by Gallagher Student Health & Special Risk within 31 days of the qualifying event. If not received within 31 days of the qualifying event, the effective date of coverage will be the date this form and payment are received at Gallagher Student Health & Special Risk. Once a dependent is enrolled, coverage cannot be terminated unless the student loses eligibility.

Students may enroll their eligible dependents online for an additional premium by visiting www.gallagherstudent.com/uniongrad, selecting "Dependent Enroll", and completing the form by the published deadline.

Online Student Waive/Enroll Process

Students who are currently enrolled in a health insurance plan that provides comparable coverage to the Union Graduate College Student Health Insurance Plan and is in effect during the 2014 - 2015 academic year can elect to waive the school sponsored Student Health Insurance Plan.

Recognizing that health insurance coverage may change, at the beginning of each academic year students will be asked to provide proof of comparable coverage to the Union Graduate College Student Health Insurance Plan in order to waive coverage.

In the event you waive coverage and then lose coverage due to a qualifying event, i.e. your parent loses coverage or you reach the maximum age limit available under a parent's plan, you have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage; for petitions received after the 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Student Health & Special Risk. The premium will not be prorated.

Enrollment Process

Students who decide they would like to enroll in the Union Graduate College Student Health Insurance Plan may do so by completing the following steps.

1. Go to www.gallagherstudent.com/uniongrad.
2. Click on "Student Waive/Enroll".
3. Create a user account or log in if you are a returning user.
4. Select the blue "I want to Waive/Enroll" button. Upon completing your online form, you will be asked to review the information provided and click "submit" to complete the process. Immediately upon submitting your online form you will receive a reference number. Please save this number and print a copy for your records. If you do not receive a reference number, you will need to correct any errors and resubmit the form.

Waiver Process

To document proof of comparable coverage an online waiver form must be completed by September 15, 2014.

1. Go to www.gallagherstudent.com/uniongrad.
2. Click on "Student Waive/Enroll".
3. Create a user account or log in if you are a returning user.
4. Select the blue "I want to Waive/Enroll" button. Upon completing your online form, you will be asked to review the information provided and click "submit" to complete the process. Immediately upon submitting your online form you will receive a reference number. Please save this number and print a copy for your records. If you do not receive a reference number, you will need to correct any errors and resubmit the form.

Union Graduate College reserves the right to audit and subsequently reject a waiver or enrollment request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage or does not meet the eligibility guidelines the student will be automatically enrolled in the Student Health Insurance Plan or the students enrollment request will not be processed.

Waiver Deadline

The deadline for processing the online waiver is September 15, 2014 for students enrolling in the fall and January 13, 2015 for students who are newly enrolled for the spring term. Students who do not meet these deadlines will remain enrolled in and billed for the Student Health Insurance Plan. Students, who complete and successfully submit a Waiver Form in the fall, waive coverage for the entire policy year. Only students who are newly enrolled at Union Graduate College for the Spring Term are allowed to waive or enroll for coverage for the Spring Term.

Plan Term

Coverage for all Insured Students for the annual enrollment period will become effective on August 1, 2014 and will terminate on July 31, 2015. For new Spring Semester Insured Students, coverage will become effective on January 1, 2015 and will terminate on July 31, 2015.

Plan Cost

	Annual 8/1/14 - 7/31/15	Fall 8/1/14 - 12/31/14	Spring/Summer 1/1/15 - 7/31/15
Student	$2,096	$915	$1,259
Spouse	$5,940	$2,601	$3,567
Child(ren)	$4,017	$1,758	$2,412

Premium Refund Policy

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

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

Prescription Drug Program

The outpatient prescription drug benefit is available through the Express Scripts Pharmacy Network. The Express Scripts Pharmacy Network includes national pharmacy chains, including CVS, Walgreens and Brooks, as well as local pharmacies. You will pay a per prescription Copayment of $20.00 for a 30 day supply of a generic drug, a per prescription Copayment of $40.00 for a 30 day supply of a brand name drug, and a per prescription Copayment of $60.00 for a 30 day supply of a non-preferred brand name drug. Insured Persons will be given an ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving an ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Gallagher Student Health & Special Risk). A listing of Express Scripts Pharmacies is available by calling 1-800-711-0917 or by visiting www.ExpressScripts.com. Not all medications are covered (See Exclusion Section).

Prescriptions are also available through a Mail Service Program. Click on "Pharmacy Program" at www.gallagherstudent.com/uniongrad to learn the details of the pharmacy program, including the Mail Service Program. Students who take maintenance drugs are encouraged to use the Mail Service Program to be able to receive the maximum benefit available.

When you use the Mail Service Prescription Drug Program you will need to complete an "Express Scripts By Mail" Order Form and mail it directly to Express Scripts along with your doctor's signed prescription form. After submitting your initial prescription, additional prescriptions can be filled by going online to www.ExpressScripts.com. A brochure describing the Mail Service Prescription Drug Program and order forms are available at www.gallagherstudent.com/uniongrad. Not all medications are covered, for example vitamins or food supplements, smoking deterrents, drugs to promote hair growth or weight loss, immunizations, and experimental drugs.

Preferred Provider Network

The Union Graduate College Student Health Insurance Plan provides access to Physicians, Hospitals and other health care providers through the MagnaCare Network within the New York area, as well as throughout the United States. Network Providers are the Physicians, Hospitals and other health care providers who are contracted to provide specific medical care at negotiated prices. When Insured Students use Network Providers, out-of-pocket expenses will be less because Network Providers have agreed to accept a negotiated fee or Preferred Allowances as payment. Non-Network Providers have not agreed to a negotiated fee and are subject to a higher coinsurance. It is important that the Insured Student verify that his or her Physicians are Network Providers when calling for an appointment or at the time of service. The most efficient and accurate way to identify Network Providers is to call MagnaCare at 1-800-235-7267 or at www.magnacare.com.

24-hour Nurse Advice Line

Students may utilize the Nurse Advice Line anytime they need confidential medical advice. On Call International provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives Insured students access to a toll-free nurse information line 24-hours a day, 7 days a week. To access a wealth of useful health care information, contact the Nurse Advice Line at 1-800-850-4556.

Definitions

The terms shown below shall have the meaning given in this section whenever they appear in this Policy. Additional terms may be defined within the provision to which they apply.

Coinsurance means the percentage amount of Covered Expenses for which the Covered Person is responsible for any medical service or supply. The Coinsurance is shown in the Schedule. We will pay the remaining amount of Covered Expenses, subject to the maximum amount for specific services and the maximum benefit for all services.

Complications of pregnancy means:

a. Conditions whose diagnosis is distinct from but adversely affected or caused by pregnancy and which require a Hospital Stay (when pregnancy is not terminated). Such conditions include, but are not limited to, acute nephritis; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; pre-eclampsia; and similar conditions of comparable severity; or

b. Non-elective cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; and spontaneous termination of a pregnancy during a period of gestation when a viable birth is not possible.

c. Complications of pregnancy do not include:

d. False labor;

e. Occasional spotting;

f. Doctor-prescribed rest during pregnancy;

g. Morning Sickness; or

h. Similar conditions associated with a difficult pregnancy that are not classified as a Complication of Pregnancy.

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.

Covered Person means the covered student and his eligible Dependents, if dependents coverage is available and the covered student has applied for such dependent's coverage and paid the required premium.

Deductible means the amount of Covered Expenses paid for the Covered Person before benefits are payable under the policy. The Deductible amount is shown in the Schedule.

Dependent means a covered student's unmarried child who:

- "Child" includes stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.

Dependent also includes the covered student's lawful spouse.

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. The Covered Person;
b. The Covered Person's spouse, dependent, parent, brother, or sister; or
c. A person who ordinarily resides with the Covered Person.

Home Country means the country where the Covered Person permanently resides. Such country must be declared in advance with the United States Fire Insurance Company.

Hospital means a short-term, acute, general Hospital which:

a. Is duly licensed by the agency responsible for licensing such Hospitals;
b. Is primarily engaged in providing, by or under the continuous supervision of Doctors, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
c. Has organized department of medicine and major surgery;
d. Has a requirements that every patient must be under the care of a Doctor or dentist;
e. Provides 24-hour nursing service by or under the supervision of a registered professional Nurse (R.N.);
f. If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861 (k) of United States Public Law 89-97 (42 USCA 1395X[k]; and is not, other than incidentally:
g. A place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care; or
h. A military or veterans Hospital or a Hospital contracted for or operated by a national government or its agency unless:
    1) The services are rendered on an emergency basis; and
    2) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

Hospital Stay means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided and a per diem charge is made by the Hospital.

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.

Intensive Care means:

a. A specifically designated facility of the Hospital that provides the highest level of medical care; and
b. Is restricted to those patients who are critically ill or injured.

- Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. It must be:
    a. Permanently equipped with special life-saving equipment for the care of the critically ill or injured; and
    b. Under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to the Intensive Care Unit.
- Intensive Care does *not* mean any of these step-down units:
    a. Progressive care;
    b. Sub-acute Intensive Care;
    c. Intermediate care units;
    d. Private monitored rooms;
    e. Observation units; or
    f. Other facilities not meeting the standards for Intensive Care.

Medical Emergency means the occurrence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in:

a. Placing ones health (for a pregnant woman this includes the health of the newborn) in serious jeopardy;
b. Serious impairment to bodily functions;
c. Serious dysfunction of any body organ or part; or
d. Serious disfigurement of such person.

Expenses incurred for Medical Emergency will be paid only for an Injury or Sickness fulfilling the above conditions. These expenses will not be paid for minor Injuries.

Medically Necessary means those services or supplies provided or prescribed by a Hospital or Doctor:

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

Negative X-ray means an X-ray that shows the absence of a fracture, pathology, or disease.

Nurse means either a professional, licensed, graduate registered Nurse (R.N.) or a professional, licensed practical Nurse (L.P.N.). Nurse also includes a midwife who is certified as such by the American College of Nurse Midwives and licensed as a Registered Nurse (RN).

Pediatric Dental Care means:

a. Preventive and diagnostic services, including X-rays (bitewing, full-mouth, and panoramic) and sealants (for permanent first and second molars only, as needed);
b. Minor restorative services, including Emergency palliative treatment of pain, fillings (amalgam, resin-based composite), and simple extractions;
c. Major services, including prosthodontics, crowns, bridges, and dentures (one per tooth/arch every 60 months); endodontics, (root canals), periodontics, oral surgery, and general anesthesia in conjunction with complex oral surgery; (note: all major services require pre-authorization); and Medically Necessary orthodontia services.

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

Policyholder means the entity to which the policy is issued and the college or university that the Covered Person attends during his or her Term of Coverage. The Policyholder is shown on the first page of the policy.

Positive X-ray means an X-ray that shows the presence of a fracture, pathology, or disease.

Prescription means any authorization, including authorized refills, issued by a Doctor for dispensing medication for the purpose and in the amount specified.

Prescription drug means:

a. A legend drug;
b. A compound medication when at least one ingredient is a Prescription legend drug;
c. Any other drug which under applicable state law may only be dispensed by prescription, including injectable insulin; or
d. Drugs and medications dispensed by a licensed pharmacist that are not specifically excluded by other provisions applicable to this coverage.

Term of Coverage means the period of coverage beginning with the Covered Person's Effective Date and ending upon completion of a trimester, semester, or other measure of an academic session determined by the Policyholder.

Sickness means illness, disease, normal pregnancy for the Insured Student, and Complications 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.

Usual, Reasonable and Customary 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.

Preventive Care includes the following services when performed by a network provider.

Covered Preventive Services for Adults

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults — doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity** screening and counseling for all adults
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- **Syphilis** screening for all adults at higher risk

Covered Preventive Services for Women, Including Pregnant Women

Note: Services marked with an asterisk (*) must be covered with no cost-sharing in plan years starting on or after August 1, 2012.

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breastfeeding** comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women*
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs*
- **Domestic and interpersonal violence** screening and counseling for all women*
- **Folic Acid** supplements for women who may become pregnant
- **Gestational diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes*
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **Human Immunodeficiency Virus (HIV)** screening and counseling for sexually active women*
- **Human Papillomavirus (HPV) DNA Test:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older*
- **Osteoporosis** screening for women over age 60 depending on risk factors
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users
- **Sexually Transmitted Infections (STI)** counseling for sexually active women*
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Well-woman visits** to obtain recommended preventive services for women under 65*

Covered Preventive Services for Children

- **Alcohol and Drug Use** assessments for adolescents
- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Blood Pressure** screening for children
- **Cervical Dysplasia** screening for sexually active females

- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 — doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling and screening for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

Emergency Medical Evacuation

This benefit is available to International Students or students participating in a Union Graduate College Study Abroad Program. Combining this benefit with the Repatriation of Remains benefit, we will pay for benefits for the Covered Expenses incurred, up to $50,000 if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. Emergency Medical Evacuation means: a) the Insured Person's medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital or home residence where appropriate medical treatment can be obtained; 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 (On Call International). Expenses for special transportation must be: (a) recommended by the attending Physician; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Physician.

Repatriation of Remains

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

Schedule of Benefits

Maximum Benefit:	Unlimited per Insured Person
Deductible Preferred Provider:	$ 150 per Policy Year
Deductible Out of Network:	$ 300 per Policy Year
Coinsurance Preferred Provider:	80% of Preferred Allowance (PA)
Coinsurance Out of Network:	60% of Usual, Reasonable & Customary (URC) Charges
Out of Pocket Limit:	$6,350 Individual / $ 12,700 Family
Preferred Provider Network:	MagnaCare will be accessed through PHX

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to an Unlimited Maximum Benefit.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Covered Medical Expenses include:

Schedule of Benefits (Con't)

Inpatient	Preferred Providers	Out-of-Network Providers
Intensive Care	80% of PA	60% of URC
Hospital Miscellaneous Expense, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of URC
Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay of at least 48 hours following A vaginal delivery or 96 hours following a Cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.	Paid as any other Sickness	
Physiotherapy	80% of PA	60% of URC
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of URC
Assistant Surgeon	80% of PA	60% of URC
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of URC
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of URC
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of URC
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of URC
Outpatient		
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 100% of the second procedure and 100% of all subsequent procedures.	80% of PA	60% of URC
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of URC
Assistant Surgeon	80% of PA	60% of URC
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of URC
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	80% of PA $25 copay/visit	60% of URC
Physiotherapy, Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy. Speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer or vocal nodules. Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	80% of PA	60% of URC
Medical Emergency Expenses, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. (The Copay/ per visit Deductible will be waived If admitted to the Hospital.)	80% of PA $150 Copay/visit	80% of URC $150 Ded/Visit
Diagnostic X-ray Services	80% of PA	60% of URC
Radiation Therapy	80% of PA	60% of URC
Chemotherapy	80% of PA	60% of URC
Laboratory Services	80% of PA	60% of URC
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of URC
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of URC

Schedule of Benefits (Con't)

Outpatient (Con't)	Preferred Providers	Out-of-Network Providers
Prescription Drugs, Express Scripts Pharmacy	Generic: $20 Copay; Brand: $40 Copay Non-Preferred Brand: $60 Copay	
Mail Order	Generic: $30 Copay; Brand: $60 Copay Non-Preferred Brand: $100 Copay	
Ambulance Services	80% of PA	60% of URC
Durable Medical Equipment, a written Prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.	80% of PA	60% of URC
Consultant Physician Fees, when requested and approved by attending Physician.	80% of PA; $25 copay/visit	60% of URC
Dental Treatment, made necessary by Injury to Natural Teeth only. $500 *for each Injury* (*Benefits are not subject to the Unlimited Maximum Benefit.*)	80% of PA	60% of URC
Diabetes Services, in connection with the treatment of diabetes.	Paid as any other Sickness	
Mental Illness Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered. See also Benefits for Severe Mental Illnesses and Serious Emotional Disturbances.	Paid as any other Sickness	
Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered.	Paid as any other Sickness	
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy for 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas.	Paid as any other Sickness	
Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the mother earlier.	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Preventive Care Services (copays & deductibles do not apply)	100% of PA	70% of URC
Pediatric Dental limited to Covered Persons under the age of 19; includes coverage for preventive and diagnostic, minor restorative, major, and medically necessary orthodontia services; waiting periods and other limitations may apply; pre-authorization is required for major and orthodontic care; benefits are subject to the medical Deductible and Out-of-Pocket Maximum; see definition for further information	Paid as any other Sickness	
Pediatric Vision limited to Covered Persons under the age of 19; includes one exam/fitting per policy year, including prescription eyeglasses (lenses and frames, limited to one per year) or contact lenses (in lieu of eyeglasses)	Paid as any other Sickness	
Hospice Care, services rendered from a licensed hospice agency and when recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less.	80% of PA	60% of URC
Skilled Nursing Facility, services received while confines as a full-time Inpatient in a licensed Skilled Nursing Facility in lieu of or within 24 hours following a Hospital Confinement.	80% of PA	60% of URC
Urgent Care Center, facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be Paid as specified in the Schedule of Benefits. (*Policy deductible does not apply*).	80% of PA $75 Copay/Visit	60% of URC $75 Ded/Visit
AD&D	Up to $10,000	

Additional Benefits

These benefits are provided: 1) to the extent that the type of Expense is covered under the plan; and 2) at the same payment level as any other Sickness or Injury, unless otherwise stated below.

Outpatient Mental, Nervous or Emotional Disorders or Ailments Expense: We will pay the outpatient Expense for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, including biologically based mental illness for adults and children; and children with serious emotional disturbances, to the same extent as any other Sickness. Coverage includes the services of a licensed psychiatrist, licensed psychologist, a certified clinical social worker, or a professional corporation or university faculty practice corporation. Such benefits may be limited to not less than 20 visits in any plan year.

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.

Children with serious emotional disturbances means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

1) Serious suicidal symptoms of other life-threatening self-destructive behaviors;
2) Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
3) Behavior caused by emotional disturbances that place the child at risk of causing personal Injury or significant property damage; or
4) Behavior caused by emotional disturbance that place the child at substantial risk of removal from the household.

Inpatient Mental, Nervous or Emotional Disorders or Ailments Expense: We will pay the inpatient Expense for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, including biologically based mental illness for adults and children; and children with serious emotional disturbances, to the same extent as any other Sickness. Such benefits may be limited to not less than 30 days of active treatment in any plan year. If the Insured requires partial hospitalization, two partial hospitalization days will equal one inpatient day.

Active treatment means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.

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.

Children with serious emotional disturbances means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

1) Serious suicidal symptoms of other life-threatening self-destructive behaviors;
2) Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
3) Behavior caused by emotional disturbances that place the child at risk of causing personal Injury or significant property damage; or
4) Behavior caused by emotional disturbance that place the child at substantial risk of removal from the household.

Pre-Admission Tests Expense: We will pay the Hospital Expense for the use of outpatient facilities as needed for tests before an Insured is admitted for surgery, provided that: a) tests are required for diagnosis and treatment of the ailment for which surgery will be done; b) a Hospital bed and operating room have been reserved before the tests are made; c) the surgery is done within seven days after the tests; and d) the Insured is physically present for tests.

Emergency Medical Expense: We will pay the emergency medical services Expenses of a Hospital if an Insured is covered for inpatient Hospital Expenses. Emergency medical services means care for a sudden onset of an ailment which could place the Insured's life in danger if not treated at once. We do not pay such Expenses unless the care is given within: a) 12 hours after the illness begins; or b) 72 hours after an Accident.

Elective Surgical Second Opinion Expense: If surgery is recommended, We will pay for a second opinion from a board certified specialist in the field relating to the surgical procedure proposed. Our payment will include the Expense for x-rays and diagnostic tests.

Chiropractic Care Expense Benefit: Benefits will be payable for an Covered 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. Charges are treated the same way as any other Sickness.

Home Health Care Expense: If, as a result of a covered Sickness, an Insured shall incur home health care Expenses. We will pay 80% of such Usual, Reasonable and Customary Expenses incurred within 12 months from the date of the first home health care visit. Such reimbursement is subject to an annual Deductible of $50 and the maximum number of covered visits is limited to 40. Four hours of home health aide service shall be considered as one home care visit.

Chemical Abuse or Dependence Outpatient Benefits Expense: If You or Your dependent, while insured under this provision, incurs Expense for the outpatient treatment provided by an alcoholism or substance abuse treatment facility or an alcoholism or substance abuse treatment program, We will pay the greater of: a) outpatient benefits in the same manner as any other Sickness, but not to exceed: 1) one visit each day for any one Insured person; or 2) 60 visits in any calendar year; or b) outpatient benefits as otherwise provided under the plan for alcohol or substance abuse. Under part a) above, up to 20 of the 60 visits may consist of counseling for insured family members of the Insured person, even if the Insured person does not receive treatment. Such coverage is limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Services and, in other states, to those which are accredited by The Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse or chemical dependence treatment programs.

Chemical Abuse or Dependence Inpatient Benefits Expense: If You or Your dependent, while insured under this provision, incurs

Expense for diagnosis and treatment, We will pay, consistent with the level of benefits for other diseases covered under the plan: 1) up to seven days of care during any calendar year for active treatment for chemical dependency and 2) up to 30 days of care during any calendar year for rehabilitation services. Such coverage is limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Services and, in other states, to those which are accredited by The Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse or chemical dependence treatment programs. No chemical abuse or dependence inpatient coverage is provided under any supplemental Expense benefits which may be provided under the plan.

Maternity Inpatient Care Expense: We will pay the Expense incurred in connection with: a) inpatient hospitalization services for a covered mother and a newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery; and b) 96 hours after delivery by an uncomplicated cesarean section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a written agreement pursuant to Section 6951 of the Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. Maternity care coverage shall also include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. The covered mother shall have the option to be discharged earlier than the time periods established in or b) above. In such case, the inpatient Hospital coverage must include at least one home care visit which shall be in addition to, rather in lieu of, any home health care coverage available under the plan. The plan will cover the home care visit which may be requested at any time within 48 hours of the time of delivery (96 hours in the case of a cesarean section), and shall be delivered within 24 hours, (i) after discharge, or (ii) of the time of the mother's request, whichever is later. Such home care coverage shall not be subject to Deductibles, coinsurance or copayments.

Mammography Expense: We will pay the Expense for mammography screening for occult breast cancer: a) upon the recommendation of a Physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer; b) a single baseline mammogram for covered persons ages 35 through 39, inclusive; and c) an annual mammogram for covered persons ages 40 and older.

Breast Reconstruction Expense: We will pay the Expense incurred in connection with breast reconstruction. This shall include reconstruction after a mastectomy for: a) all stages of reconstruction of the breast on which the mastectomy has been performed; and surgery and reconstruction of the other breast to produce a symmetrical appearance in a manner determined by the attending Physician and the patient to be appropriate.

Cervical Cytology Screening Expense: We will pay the Expense for annual cervical cytology for cervical cancer and its precursor for women ages 18 and older. Cervical cytology screening shall include an annual pelvic examination, collection and preparation of a pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the pap smear.

Enteral Formulas Expense Benefit: Benefits will be payable 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, which if left untreated will cause chronic physical disability, mental retardation or death. Benefits will covered enteral formulas and food products 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. Also covered are 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. Charges are treated the same way as any other Sickness.

Diabetes Equipment, Supplies and Education Expense: We will pay the Expense incurred in connection with the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a Physician or other licensed health care provider legally authorized to prescribe under Title Eight of the Education Law: a) blood glucose monitors; b) blood glucose monitors for the legally blind and visually impaired; c) data management systems; d) test strips for glucose monitors; e) visual reading and urine test strips; f) insulin; g) injection aids; h) cartridges for the legally blind and visually impaired; i) syringes; j) insulin pumps and appurtenances thereto; k) insulin infusion devices; and 1) oral agents for controlling blood sugar. We will also provide coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits Medically Necessary upon the diagnosis of diabetes, where a Physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the Physician or other licensed health care provider legally authorized to prescribe under Title Eight of the Education Law, or their staff as part of an office visit for diabetes or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral of a Physician or other licensed health care provider legally authorized to prescribe under Title Eight of the Education law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when Medically Necessary.

Mastectomy Care Expense: We will pay the Expense for coverage for inpatient Hospital care for such period as is determined by the attending Physician, in consultation with the patient, to be medically appropriate for such covered person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the plan.

Clinical Trials Expense: We will pay the Expense incurred in connection with an Insured's costs in a clinical trial. Clinical trial means a peer-reviewed study plan which has been: 1) reviewed and approved by a qualified institutional review board and 2) approved by one of the National Institutes of Health (NIH) or NIH cooperative group or an NIH center; or the Food and Drug Administration in the form of an investigational new drug exemption; or the Federal Department of Veteran Affairs; or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants; or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

Prostate Cancer Expense: We will pay the Expense for 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 an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

Bone Density Measurements and Testing Expense: We will pay the Expense for bone density measurements and testing when the Insured person meets the eligibility criteria under the Medicare program or those set by the National Institutes of Health (NIH) for the detection of osteoporosis. We will cover the Expense for drugs and devices when the plan has prescription drug and/or durable medical equipment coverage. Qualified Insured persons must have at a minimum: a) a previous diagnosis or family history of osteoporosis; or b) symptoms or conditions indicative of the presence or significant risk of osteoporosis; or c) on a prescribed drug regimen posing a significant risk of osteoporosis; or d) lifestyle factors posing a significant risk of osteoporosis; ore) age, gender and/or physiological characteristics which pose a significant risk of osteoporosis.

Pre-Hospital Emergency Medical Services Expense: We will pay the Expense for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service.

Investigational/Experimental Expense: We will pay the Expense for a health care service, rendered or proposed to be rendered to an Insured on the basis that such service is experimental or investigational, is rendered as part of a clinical trial or a prescribed pharmaceutical product, provided that coverage of the patient costs of such service has been recommended for the Insured by an external appeal agent upon an appeal. The determination of the external appeal agent shall be binding.

Autism Spectrum Disorder Expense: We will pay the Expense incurred for the diagnosis and treatment of an autism spectrum disorder. "Autism spectrum disorder" means a neurobiological condition that includes autism, Asperger syndrome, Rett's syndrome, or pervasive developmental disorder.

Cancer Second Opinion Expense Benefit: Benefits will be payable for 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 or treatment for cancer. Charges are treated the same way as any other Sickness.

End of Life Care Expense Benefit: Benefits will be payable if diagnosed with Advanced Cancer, covered services include services provided by a facility or program specializing in the treatment of terminally ill patients if the Covered Person's attending Doctor, in consultation with the medical director of the facility or program determines that the Covered Person's care would appropriately be provided by such a facility or program.

"Advanced Cancer," means a diagnosis of cancer by the attending health care practitioner certifying that here is no hope of reversal of primary disease and that the person has fewer than sixty days to life. Charges are treated the same way as any other Sickness.

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 Policy, issued to and on file with Union Graduate College.

Termination of Insurance

Benefits are payable under the Plan only for that covered expense incurred while the Plan is in effect as to the Insured. No benefits are payable for expense incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

Continuous Coverage: If a **covered person** was continuously covered under this or a similar preceding plan offered through Union Graduate College, any **sickness** diagnosed or **injury** sustained while so covered will not be considered a Pre-Existing Condition when such person becomes covered under this Certificate, provided the **covered person** enrolls for this coverage within 63-days of the end of the preceding company's plan, The Covered Person will be considered to have maintained continuous coverage, except for expenses that are the liability of the previous plan. Coverage cannot be considered continuous if a break in enrollment of more than 63-days occurs.

Notice of Claim: Written notice must be given to Us within 90 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given to Our authorized representative. Notice should include the Plan holder's name and number and the Covered Person's name and address.

On Call International-Travel Assistance Plan

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 of Friend Transportation Arrangements, and Return of Minor Children. All transportation related services; coverage and payments must be arranged and pre-approved by On Call International.

Worldwide emergency medical, legal and travel assistance services are available 24 hours a day, 365 days a year.

For Assistance call:
In the U.S., toll free – 1-866-509-7715
Worldwide, collect – 1-603-328-1728

Gallagher Student Complements

Exclusively from Gallagher Student Health & Special Risk, enrolled students have access to the following menu of products at no additional cost. These plans are not underwritten by United States Fire Insurance Company. More information is available at www.gallagherstudent.com/uniongrad.

EyeMed Vision Care

The discount vision plan is available through EyeMed Vision Care. EyeMed's provider network offers access to over 45,000 independent providers and retail stores nationwide, including LensCrafters, Sears Optical, Target Optical, JC Penney Optical, and most Pearle Vision locations. You will receive a separate EyeMed ID card. There is no waiting period; you can take advantage of the savings immediately upon receipt of your EyeMed ID card. You can purchase prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses at savings between 15% to 45% off regular retail pricing.

In addition, you can receive discounts from 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons. You can call 1-866-8EYEMED or go online to www.eyemedvisioncare.com and choose the Access network from the drop down network option.

Basix Dental Savings

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides a wide range of dental services. It is important to understand the ***Dental Savings Program is not dental insurance.*** Basix contracts with dentists that agree to charge a negotiated fee to students covered under your Gallagher Student Health & Special Risk plan. You must pay for the services received at the time of service to receive the negotiated rate.

Savings vary but can be as high as 50% depending upon the type of service received and the contracted dentist providing the service. To use the program, simply:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on our website, www.basixstudent.com.
- Tell the dental office that you are an insured student and have to the Basix program. Each dentist has an administrative person to assist you with any questions. You do not need a separate identification card for the Basix program, but you will need to show your student health insurance ID card to confirm your eligibility. If the office needs to check eligibility, call Gallagher Student Health & Special Risk at 877-320-4347.
- Remember, you must pay for the services you receive at the time of service, so make sure you understand what forms of payment (check, credit card, etc.) the dentist accepts.

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

CampusFit

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

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

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

Accidental Death and Dismemberment Benefit

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

For the Loss of	Amount
Life	$5,000
Two hands	$5,000
Two feet	$5,000
Sight of two eyes	$5,000
One hand and one foot	$5,000
One hand and sight of one eye	$5,000
One foot and sight of one eye	$5,000
One hand or one foot or one eye	$2,500

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. Only one of the amounts named above will be paid for Injuries resulting from any one accident. The amount so paid shall be the largest amount that applies.

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

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

Exclusions

No benefits will be paid for loss or expense caused by or resulting from:

1. Services for which no charge is normally made including but not limited to services and supplies furnished by the Policyholder's infirmary, its employees or Doctors who work for the Policyholder and services covered and provided by the student health fee.
2. Eye examinations, prescriptions or fitting of eyeglasses and contact lenses, or other treatment for visual defects and problems, unless payable as a Covered Expense associated with an Injury covered by the policy.
3. Hearing examinations or hearing aids, or other treatment for hearing defects and problems, unless payable as a Covered Expense associated with an Injury covered by the policy.
4. Dental Treatment, except as specifically provided for in the Schedule and in the Dental Treatment benefit.
5. War or any act of war, declared or undeclared; or service in the armed forces of any country.
6. Participation in a felony, riot or insurrection;
7. Injury sustained while participating in interscholastic sports contest or competition, unless specifically listed in the Schedule or provided by rider, and including: (a) traveling to or from such sport, contest or competition as a participant; or (b) during participation in any practice or conditioning program for such sport, contest, or competition.
8. Flight in any kind of aircraft, except while riding as passenger on a regularly scheduled flight of a commercial airline, including skydiving; parachuting, hang gliding, glider flying, parasailing, or sail planing.
9. Cosmetic surgery, except cosmetic surgery for reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect or following a mastectomy.
10. Elective treatment that does not treat Sickness or Injury or is not shown as a Covered Expense or is not a New York mandated benefit.

11. Treatment in a military or Veterans Hospital or a Hospital contracted for or operated by a national government or its agency unless: (a) the services are rendered on an Medical Emergency basis; and (b) a legal liability exists for the charges made to the Covered Person for the services given in the absence of insurance.
12. Any treatment for mental and nervous disorders, unless provided by a Rider attached to the Policy or otherwise mandated by New York law.
13. Any loss covered by state or federal worker's compensation law, employers liability law, occupational disease law, or similar laws or act.
14. Rest cures or custodial care.

Extension of Benefits after Termination

The coverage provided under this plan ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date. The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

If the Insured is also an Insured under the succeeding plan issued to the Plan holder; this "Extension of Benefits" provision will not apply.

Subrogation and Right of Recovery

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

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

Claims Procedures

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

1. A claim form is not required to submit a claim. However, an itemized medical bill, HCFA 1500, or UB-92 form should be used to submit expenses. The Insured Student/Person's name and identification number need to be included.
2. The form(s) should be mailed within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail a copy to the Claims Administrator, HealthSmart at the address on the back cover.
3. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Health Smart.

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 would like additional information or have a complaint concerning the denial, please contact HealthSmart Benefit Solutions our Third Party Administrator (TPA), at 877-349-9017. HealthSmart Benefit Solutions will address concerns and attempt to resolve the complaint. If Klais is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to HealthSmart. Please include Your name, social security number, home address, plan 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. HealthSmart will acknowledge Your appeal within 10 working days of receipt or within 72 hours if the involves a life-threatening situation. A decision will be sent to You within 30 days. If there are extraordinary circumstances involved, HealthSmart 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.nv.us/extarocia.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.

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 insureds 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 plan by calling us toll-free at 877-349-9017 or by visiting us at www.HealthSmart.com.

Questions? Need More Information?

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

Gallagher Student Health & Special Risk
500 Victory Rd.
Quincy, MA 02171
Phone: 617-769-6020 or Toll free 1-877-439-1008
Email: uniongradstudent@gallagherstudent.com
Website: www.gallagherstudent.com/uniongrad

If you need medical attention before the ID card is received, benefits will be payable according to the Plan. You do not need an ID card to be eligible to receive benefits. Call Gallagher Student Health & Special Risk to verify eligibility.

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

HealthSmart Benefit Solutions
3320 West Market St., Suite 100
Fairlawn, OH 44333
Phone: 1-877-349-9017
Email: akronclaims@healthsmart.com
Website: www.healthsmart.com

This plan is underwritten by:

United States Fire Insurance Company
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Plan Number US096494

Please keep this brochure as a general summary of the insurance plan. The Policy (Form AH-27261), issued to, and on file, at the College contains all the benefit provisions, exclusions and qualifications of your insurance coverage. The Policy is the contract and in the event of a discrepancy, the Policy will govern and control the payment of benefits.