Nyack College
Graduate
Student Accident
and Sickness Plan

NYACK COLLEGE
1 South Boulevard
Nyack, NY
(“The Policyholder”)

2011-2012

Administrator Policy Number: CHH0071392
Underwriter Reference Number: CAS9492031

Underwritten by:
National Union Fire Insurance Company of
Pittsburgh, Pa. (“the Company”),
with its principal place of business in
New York, NY

This brochure is a brief description of the Student Accident and Sickness Insurance Plan available under policy series S30494NUFIC-NY. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy on file with the Policyholder. If there is any conflict between the contents of this document and the Policy, the Policy will govern in all cases.
# TABLE OF CONTENTS

Introduction.................................................................................2
Eligibility ..................................................................................2
Waiver Process/Procedure .........................................................2
Waiver Deadlines ......................................................................3
Enrollment Process/Deadline and Qualifying Events .......................3-4
Effective and Termination Dates ..................................................4
Premium Rates Student Accident and Sickness Plan .......................5
Student Accident and Sickness Plan
Description of Benefits
   Section I ...............................................................................5
   Section II ...........................................................................6-9
   Section III ..........................................................................9
Definitions ..................................................................................10-15
Extension of Benefits .................................................................15
Repatriation of Remains ...............................................................16
Medical Evacuation ..................................................................16
Coordination of Benefits ...............................................................16
Mandated Benefits ..................................................................16
Conformity with State Statutes .....................................................17
Exclusions and Limitations ..........................................................17-18
Pre-Existing Conditions Limitation ..............................................18-19
   Certificate of Creditable Coverage ..........................................19
Right of Recovery .......................................................................20
Claim Procedure .......................................................................20-21
Plan Manager ...........................................................................21
Travel Guard ...........................................................................21-23
Important Numbers ...................................................................24
INTRODUCTION
Dear Students:
Hospitalization, surgery and accompanying expenses are at an all time high. Many students and their parents are not prepared to meet the added costs for unexpected Accidents or Sickness. Although many families have some form of health insurance, these plans may not cover a college student after age 19 or have large deductibles. Costly medical bills can impose tremendous hardship and even necessitate withdrawal from school.
The College is concerned with the health and well-being of its students and has created a student accident and sickness plan for its students.
Please read this descriptive brochure in its entirety.

ELIGIBILITY
Rockland Campus Only:
Full-time resident graduate students (12 or more credit hours, 9 or more credit hours for MSOL and MBA) will be automatically enrolled in the Student Accident and Sickness Plan and charged the premium on their tuition bill unless proof of other comparable coverage is provided. A full-time resident graduate student who initially waived coverage under the Policy but subsequently experiences ineligibility under another creditable plan may elect to enroll for coverage under the Policy within 30 days of the date of ineligibility under the other creditable plan. Proof is required at time of enrollment.

WAIVER PROCESS/PROCEDURE
Full-time resident graduate students, who are currently insured by a health insurance policy may waive out of the Student Accident and Sickness Plan with proof of comparable coverage. The waiver form must be completed online at www.cirstudenthealth.com/nyack. Online waivers must be completed by the waiver deadline in order to have the premium removed from the tuition bill. Failure to meet the waiver deadline will result in the student being responsible for the insurance premium.

WAIVER DEADLINES
Fall Semester: September 30, 2011
*Spring/Summer Semester: February 6, 2012
*Spring/Summer coverage period is available only to new students to Nyack College.

All Campuses:
All non-resident full-time and part-time graduate students (taking at least 6 credit hours) may choose to purchase the Student Accident and Sickness Plan on a voluntary basis by completing the enrollment process online at www.cirstudenthealth.com/nyack and paying the appropriate premium by the enrollment deadline.
Covered students may also enroll their eligible dependents. Eligible dependents are (a) the Covered Student’s spouse residing with the Covered Student and (b) the Covered Student’s unmarried child under age 19. The term “child” includes: (a) a Covered Student’s legally adopted child; (b) child who has been placed in the Covered Student’s home pending adoption procedures; and (c) a Covered Student’s step-child if such child depends on the Covered Student for full support. Dependents must be enrolled for the same coverage and coverage term for which the Covered Student enrolls. An eligible student may enroll his or her dependents for coverage by completing the enrollment process at www.cirstudenthealth.com/nyack by the enrollment deadline, or within 30 days of marriage, birth, or adoption, for which proof is required, by contacting Maksin Management Corp at 877-440-6840.

ENROLLMENT PROCESS/DEADLINE AND QUALIFYING EVENTS
Graduate students and dependents eligible to enroll on a voluntary basis may do so by completing the enrollment process online at www.cirstudenthealth.com/nyack and paying the appropriate premium by the enrollment deadline. Enrollment will end September 30, 2011 for the Fall coverage period and February 6, 2012 for the Spring/Summer coverage period.*
No enrollment will be accepted after these enrollment deadlines. The only exception are the following
qualifying events with the appropriate documentation: (1) adding a new spouse or dependent child within 30 days of marriage, birth or adoption; or (2) within 30 days of ineligibility under another creditable plan. 

*Spring/Summer coverage period is available only to new students to Nyack College.

EFFECTIVE AND TERMINATION DATES
The Master Policy becomes effective at 12:01 a.m. on September 1, 2011 and it terminates at 12:01 a.m. on September 1, 2012. Coverage for Covered Students will be effective on: (a) the Policy Effective Date; (b) the Effective Date of the coverage period elected; or (c) the day after the date the enrollment form and correct premium are received, whichever is latest. Coverage terminates for the Covered Person on the earliest of a) the date the Policy terminates; b) the last day for which premium has been paid; or, c) the date he or she enters the armed forces. Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made to such persons upon written request received by the Company. 

No other refunds of premiums will be allowed.

Eligibility requirements must be met each time premium is paid to continue coverage.

PREMIUM RATES STUDENT ACCIDENT AND SICKNESS PLAN

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Spring/Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9/1/11-9/1/12</td>
<td>1/2/12-9/1/12</td>
</tr>
<tr>
<td>Full-Time Resident Students</td>
<td>$ 834.00</td>
<td>$ 550.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$1,668.00</td>
<td>$1,100.00</td>
</tr>
<tr>
<td>Each Child</td>
<td>$1,368.00</td>
<td>$ 902.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Spring/Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9/1/11-9/1/12</td>
<td>1/2/12-9/1/12</td>
</tr>
<tr>
<td>Full-Time and Part-Time Non-Resident Students</td>
<td>$1,051.00</td>
<td>$ 694.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$3,153.00</td>
<td>$2,082.00</td>
</tr>
<tr>
<td>Each Child</td>
<td>$2,102.00</td>
<td>$1,388.00</td>
</tr>
</tbody>
</table>

*Spring/Summer coverage period is available only to new students to Nyack College.

STUDENT ACCIDENT AND SICKNESS PLAN DESCRIPTION OF BENEFITS

SECTION I

BASIC ACCIDENT BENEFITS: The Company will pay the Eligible Expenses incurred within the Policy Year up to an aggregate maximum of $2,500 per Injury*, after a $50 deductible per Injury, when the Covered Person’s Injury requires (a) services by a Doctor; (b) Hospital confinement; (c) services of a licensed practical nurse or RN; (d) x-ray service; (e) use of an emergency room; (f) use of an operating room, anesthesia, including the administration thereof, or laboratory service; (g) use of an ambulatory surgical center or ambulatory medical center; (i) if ordered by a Doctor, prescription medicines, drugs, or any other therapeutic services or supplies; or (j) home health care. The benefit includes coverage for treatment of Injury to sound, natural teeth.

*Benefits for treatment of Injuries arising from participation in interscholastic sports or club football are limited to $1,000 per Injury.
SECTION II

BASIC SICKNESS BENEFITS: When a Covered Person suffers a loss from Sickness, the Company will pay the Eligible Expenses incurred, as allocated below, up to an aggregate maximum of $2,500 per Sickness.

Hospital Room and Board Expense: When the Covered Person’s Sickness requires Hospital confinement, the Company will pay the Eligible Expenses incurred for Hospital room and board up to the average semi-private rate, not to exceed $350 per day, for a maximum of 31 days per Sickness.

Hospital Miscellaneous Expense: The Company will pay Eligible Expenses incurred by the Covered Person during a Hospital confinement or as an outpatient for day surgery for services provided by a Hospital, ambulatory surgical center or ambulatory medical center up to a maximum of $1,500 per Sickness. The Company will pay for anesthesia, operating room, laboratory tests and x-rays (including professional fees), oxygen, drugs (excluding take-home drugs), medicines, dressings, pre-admission testing provided surgery is performed within 7 days of testing, and other Medically Necessary non-room and board expenses.

Surgical Expense: When the Covered Person’s Sickness requires surgery, the Company will pay 80% of the Eligible Expense, subject to the maximum surgical benefit of $2,000 per Sickness. Only one surgical procedure will be covered when multiple procedures are performed, unless Medically Necessary. If the surgery requires the services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed, the Company will pay the Eligible Expenses incurred up to a maximum of $500 per Sickness. If the surgery requires the services of an assistant surgeon, the Company will pay the Eligible Expenses incurred up to a maximum of $400 per Sickness.

In-Hospital Doctor’s Fees Expense: If, while confined to a Hospital, the Covered Person’s Sickness requires the services of a Doctor, the Company will pay the Eligible Expenses incurred for such services up to $50 per day after a $10 deductible per day, up to a maximum of 5 days per Sickness.

Consultant or Specialist Expense: When the Covered Person’s Sickness requires the services of a consultant or specialist, as requested by the attending Doctor, the Company will pay the Eligible Expenses incurred up to a maximum of $125 per Sickness, after a $25 deductible per Sickness.

Outpatient Doctor’s Fees Expense: When the Covered Person’s Sickness requires the services of a Doctor, while not confined to a Hospital, the Company will pay the Eligible Expenses incurred up to a maximum of $50 per visit, beginning with the second visit. Note: benefits will begin with the first visit if the Covered Person is referred by the Health Services Department.

Outpatient Diagnostic X-ray and Laboratory Expense: When the Covered Person’s Sickness requires diagnostic x-ray, including ultrasound, MRI and CAT Scan, or laboratory services, under the Doctor’s direction, the Company will pay the Eligible Expenses incurred up to a maximum of $1,500 per Sickness, after a $10 deductible per Sickness. Eligible Expenses for a Mammography and Cervical Cytology Screening shall not be subject to the deductible.

Outpatient Expense: When the Covered Person’s Sickness requires the use of outpatient facilities of a Hospital for an emergency room, and supplies, under the Doctor’s direction, the Company will pay the Eligible Expenses incurred up to a maximum of $5,000 per Sickness, after a $100 deductible per Sickness.

Outpatient Prescribed Medicines Expense: When the Covered Person’s Sickness requires prescribed medicines, the Company will pay 80% of the Eligible Expenses incurred for generic and 50% of Eligible Expenses incurred for brand-name, up to a maximum of $100 per Sickness, after a $10 deductible per Sickness.

The following will also be included in this benefit:

- Drug Coverage for Treatment of Cancer: Drugs not approved by the federal Food and Drug Administration for the treatment of the specific type cancer if the drug is recognized for treatment of the specific type of cancer in one of the standard reference compendia: No benefits will be payable for any drug which the Food and Drug
Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed. This shall include coverage for Medically Necessary services associated with the administration of the drug to be contraindicated; and

• Prescribed Contraceptives:
  (a) prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA) or its generic equivalents approved as substitutes by such Food and Drug Administration (FDA) under the prescription of a Doctor; and
  (b) outpatient contraceptive services, including consultations, examinations, procedures and medical services directly related to the use of contraceptive methods to prevent unplanned pregnancy; and
  (c) insertion or removal and Medically Necessary examination associated with the use of such Food and Drug Administration (FDA) approved contraceptive drug or device.

Ambulance Expense: When the Covered Person’s Sickness requires the use of an ambulance or air ambulance, the Company will pay the Eligible Expenses incurred.


Chemical Abuse or Dependence Inpatient Expense: The Company will pay Eligible Expenses for a Covered Person for diagnosis and treatment consistent with the level of benefits for any other Sickness under the Policy: 1) up to seven days of care during any Policy Year for active treatment for chemical dependency and 2) up to 30 days of care during any Policy Year for rehabilitations services. Such coverage is limited to Eligible Expenses incurred in a Hospital, Residential Treatment Facility or Intermediate Care Facility.

Chemical Abuse or Dependence Outpatient Expense: For Eligible Expenses for a Covered Person for outpatient treatment provided by an alcoholism or substance abuse treatment facility or an alcoholism or substance abuse treatment program, the Company will pay the greater of: a) outpatient benefits in the same manner as any other Sickness, but not to exceed: 1) one visit per day for any Covered Person; or 2) 60 visits per Policy Year; or b) outpatient benefits as otherwise provided under the Policy for alcohol or substance abuse. Under part a) above, up to 20 of the 60 visits may consist of counseling for Covered family members of the Covered Person, even if the Covered 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.

SECTION III - SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFITS: After the Company has paid the aggregate maximum of $2,500 per Injury or Sickness under the Basic Accident Benefits or Basic Sickness Benefits, the Company will pay 80% of additional Eligible Expenses incurred up to an aggregate maximum of $10,000 per Injury or Sickness. Eligible Expenses for daily Hospital room and board will be limited to the average semi-private room rate.
DEFINITIONS

**Accident** means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

**Biologically Based Mental Illness** means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. The following disorders covered by this definition are: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders; anorexia; and bulimia.

**Covered Person** means a Covered Student while coverage under the Policy is in effect and those dependents with respect to whom a Covered Student is insured.

**Doctor** means: (a) legally qualified physician licensed by the state in which he or she practices; and (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 such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s immediate family member.

**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 Covered Person’s effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.

**Eligible Expense** means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

**Emergency Medical Condition** means a Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following: (a) the Covered Person’s life could be in serious jeopardy; (b) bodily functions would be seriously impaired; or (c) a body organ or part would be seriously damaged; or (d) serious disfigurement. Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

**Experimental/Investigational** means a drug, device or medical care or treatment that meets the following: (a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; (b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law; (c) the drug, device, medical care or treatment or the patient’s informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval; (d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or
diagnosis; or (e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis. Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Covered Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

**Hospital** means a short-term, acute, general hospital, which: (a) 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 and sick persons; (b) has organized departments of medicine and major surgery; (c) has a requirement that every patient must be under the care of a Doctor or dentist; (d) provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); (e) 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 USCA1395x[k] ); (f) is duly licensed by the agency responsible for licensing such hospitals; and (g) is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

**Injury** means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

**Intermediate Care Facility** means a facility which provides for the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, any of the following therapeutic techniques, as identified in a treatment for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(a) chemotherapy;
(b) counseling;
(c) detoxification services;
(d) other ancillary services, such as medical testing, diagnostic evaluation and referral to other services identified in the treatment plan.

**Medical Necessity/Medically Necessary** means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided. A service or supply will not be considered as Medically Necessary if: (a) it is provided only as a convenience to the Covered Person or provider; or (b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or (d) it is Experimental/Investigational or for research purposes; or (e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or (f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or (g) involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual or Center for Medicare and Medicaid Services Issues Manual; or (h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment. The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**Mental or Nervous Disorder(s)** means any condition or disease regardless of its cause, listed in the most
recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (other than those conditions caused by Biologically Based Mental Illness, or with respect to a Dependent child under age eighteen (18), Serious Emotional Disturbance) on the date the medical care or treatment is rendered to the Covered Person.

**Pre-Existing Condition** means a Sickness, Injury or condition, whether physical or mental, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the Covered Person’s effective date of coverage under the Policy or a pregnancy existing on the Covered Person’s effective date of Coverage under the Policy. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information.

**Reasonable and Customary** means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing. “Geographic area” means the three digit zipcode in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply. Reasonable and Customary charges also means the 90th percentile of the payment system in effect on the Effective Date.

**Residential Treatment Facility** means a facility which provides 24 hour treatment for people with drug abuse, alcohol abuse on an inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services. The Company will recognize a Residential Treatment Facility if it’s accredited for its stated purpose by the Joint Commission, and carries out its stated purpose in compliance with all relevant state and local laws.

**Serious Emotional Disturbances**—applicable only to children under age eighteen (18), means a child who has a diagnosis of attention deficit disorder, disruptive behavior disorder, or pervasive development disorder and one or more of the following: serious suicidal symptoms or other life-threatening self-destructive behavior; significant psychotic symptoms (hallucinations, delusion, bizarre behavior); behavior caused by emotional disturbance that places the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbance that places the child at substantial risk of removal from the household.

**Sickness** means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and complications of pregnancy. All Sickneses due to the same or a related cause are considered one Sickness.

**EXTENSION OF BENEFITS**

If the Covered Person is receiving treatment for a Sickness or Injury on the date the Policy terminates, Eligible Expenses shall include charges incurred for that Sickness or Injury, but only while they are incurred during the 12 month period following such termination of insurance, subject to the applicable Maximum Amounts of the Policy.

**In The Event Of Pregnancy.** If a Covered Person is pregnant on the date the Policy terminates and the pregnancy commenced while insured while the Policy was in force, benefits will be payable for Eligible Expenses incurred after the Policy terminates until the earliest of: (a) the date the pregnancy ends; (b) the date the Covered Person becomes insured under another policy; or (c) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.
REPATRIATION OF REMAINS

Maximum Amount: $10,000

In the event an Injury or Sickness causes death while the Covered Person is outside a 100 mile radius from his or her current place of primary residence, the Company will pay eligible expenses incurred to transport his or her body to a mortuary near his or her current place of primary residence.

MEDICAL EVACUATION

Maximum Amount: $10,000

The Policy will pay for evacuation to the nearest adequate medical facility following a covered Injury or Sickness if the Covered Person is outside a 100 mile radius from his or her current place of primary residence and his or her Doctor determines that adequate medical treatment is not locally available.

COORDINATION OF BENEFITS

Benefits for Accidents and Sickness are coordinated with other health insurance the Covered Person may have in force as described in the Policy.

MANDATED BENEFITS

Coverage for the following benefits to be paid as any other Sickness except under certain coverages wherein there are internal limits: Biologically based Mental Illness/Serious Emotional Disturbances and Mental and Nervous Disorders; Breast Cancer Treatment; Breast Reconstruction; Clinical Trials Expense; Outpatient Chemical Abuse and Chemical Dependence; Mammographic Examination; Cytologic Screening; Cancer Second Opinion; Diagnostic Screening for Prostate Cancer; Diabetes Treatment; End of Life Care; Pre-Hospital Medical Emergency Services; Bone Mineral Density Measurements and Tests; Medical Foods up to $2,500 per Policy Year; and Contraceptive Services. Please see the Policy on file with the College for complete details and any other applicable mandates.

CONFORMITY WITH STATE STATUTES

Any provision of this plan, which on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of such statutes.

EXCLUSIONS AND LIMITATIONS

The Policy does not cover nor provide benefits for Accident, Sickness, or treatment of a medical condition arising out of:

1. (a) mental or emotional disorders: (i) in excess of thirty (30) days for inpatient Hospital care; or (ii) in excess of twenty (20) visits for outpatient care; or (b) outpatient treatment for alcoholism and substance abuse in excess of sixty (60) visits, of which twenty (20) may be used for family members.

2. illness, accident, treatment or medical condition arising out of:
   a. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto;
   b. suicide, attempted suicide or intentionally self-inflicted injury;
   c. aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

3. cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part. However, if the policy provides hospital, surgical or medical expense coverage then coverage and determinations with respect to cosmetic surgery must be provided pursuant to New York Insurance Law 56 (Regulation 183);

4. treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or Federal workers’compensation,
employers’ liability or occupational disease law; benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; services rendered and separately billed by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made.

5. dental care or treatment, except for such care or treatment due to accidental Injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

6. eyeglasses, hearing aids, and examination for the prescription or fitting thereof.

7. rest cures, custodial care and transportation.

**PRE-EXISTING CONDITIONS LIMITATION**

Pre-existing Conditions are not covered for the first 12 months following a Covered Person’s effective date of coverage under this Policy. This limitation will not apply if: (a) the Covered Person has been covered under the Policy-holder’s prior Policy for 12 consecutive months immediately preceding the effective date of coverage under the current Policy; or (b) the individual seeking coverage under the Policy has an aggregate of 12 months of Creditable Coverage and becomes eligible and applies for coverage under this Policy within 63 days of termination of prior Creditable Coverage. Credit will be given for the time the individual was covered under the prior Creditable Coverage.

Pre-existing Conditions provision does not apply to:
(a) a newborn Dependent child; or (b) a child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while covered under the Policy; (c) pregnancy that begins 10 months from the Covered Person’s effective date of coverage under the Policy, subject to a credit for previous Creditable Coverage.

**CREDIT FOR PRIOR COVERAGE:** A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person’s effective date under the Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:
(a) a group health plan;
(b) health insurance coverage;
(c) Part A or B of Title XVIII the Social Security Act;
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(e) Chapter 55 of Title 10, United States Code;
(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a state health benefits risk pool;
(h) a health plan offered under chapter 89 of Title 5, United States Code;
(i) a public health plan (as defined in regulations);
(j) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

**CERTIFICATE OF CREDITABLE COVERAGE**

Coverage under this pan is “Creditable Coverage” under federal Law. When coverage terminates, the Covered Person can request a Certificate of Creditable Coverage, which is evidence of coverage under this plan. In order to obtain a Certificate of Creditable Coverage, please visit our website at www.maksin.com or contact Maksin Management Corp at (877)440-6840.
RIGHT OF RECOVERY

If the amount of the payments made by the Company is more than it should have paid under the COB provision, it may recover the excess from one or more of: (a) the persons it has paid or for whom it has paid; (b) insurance companies; or (c) other organizations.

CLAIM PROCEDURE

To file a claim under the Student Accident and Sickness Plan, the student should:

1. Complete a claim form, if applicable, and submit it to the Claims Administrator. Claim forms must be completed and signed for claims to be considered. Claim forms are available from Health Services, Claims Administrator or online at www.cirstudenthealth/nyack.

2. Submit itemized medical and Hospital bills within 90 days from the date of loss to the Claim Administrator. Please indicate in the student’s school name, student name, policy number and Nyack College student ID number.

3. Preauthorization and precertification of benefits to providers of medical service are not required nor provided by the Claims Administrator.

4. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator.

At Maksin Management Corp, we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more information, please go to our website at www.maksin.com.

It is the Covered Person’s responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new PolicyYear.

PLAN MANAGER

USI Affinity – CIR

Collegiate Insurance Resources
172 Bechtel Road
Collegeville, PA 19426
Phone: 1-800-322-9901
Website: www.cirstudenthealth.com/nyack

TRAVEL GUARD SERVICES

Procedures on How to Access Travel Guard 24-hour Assistance Call Center

How to Contact Travel Guard:

- Inside the US and Canada, dial 1-877-249-5362 toll-free.
- Outside the US and Canada:
  - Request an international operator.
  - Request the operator to place a collect call to the USA at 1-715-295-9625.
- Our fax number is 01-262-364-2203.

When to Contact Travel Guard:

- Call Travel Guard when you require medical assistance or have a medical emergency.
- Call Travel Guard for all non-medical situations (lost luggage, lost documents, legal help, etc.).
- Call Travel Guard whenever there is a question.
**Travel Guard is available 24-hours-a-day/7-days-a-week/365-days-a-year.**

Our multi-lingual/multi-cultural Travel Assistance Coordinators (TACs) are trained professionals ready to help you should the need arise while you are traveling or away from home.

The Travel Guard Services Medical Staff consists of full-time, onsite Registered Nurses and Emergency Physicians who work as a team to provide the best outcome for our clients. This team is directed by a dedicated Medical Director (MD) and Manager of Medical Services (RN). Nursing staff is on-site 24-hours; a physician has daily responsibility for a 24-hour period and is on-site during daytime hours.

**What information will you need to provide to Travel Guard when you call:**

- Advise Travel Guard your Claims Administrator is Maksin Management Corp.
- Provide your Policy number.
- Advise Travel Guard regarding the nature of your call and/or emergency. Be sure to provide your contact information at your current location in the event Travel Guard needs to call you back.

**Description of Services**

**Information/General:**

These services include advice and information regarding travel documentation, immunization requirements, political/environmental warnings, and information on global weather conditions. Travel Guard can also provide information on available currency exchange rates, local Bank/Government holidays, and, by implementing our databases with the information, provide ATM and Customer Service locations to clients. Travel Guard also provides emergency message storage and relay and translation services.

- Visa and Immunization
- Weather and Exchange Rates
- Environmental and Political Warnings

**Technical:** These services provide assistance to members in the event of lost or stolen luggage, personal effects, documents and tickets. Travel Guard can arrange cash transfers and vehicle return in the event of illness or accident, provide legal referrals, and help with arrangements for members who encounter enroute emergencies that force them to interrupt their trips.

- Legal Referral
- Embassy/Consulate Information
- Lost/Stolen Luggage and Personal Effects Assistance
- Lost Document Assistance and Cash Transfer Assistance
- Enroute Travel Assistance
- Claims-related Assistance
- Telephone Interpretation

**Medical:** These services are the most complicated of those offered and can last up to several weeks. They involve Travel Guard’s Medical Staff in addition to other network providers and often include post-case payment/billing coordination on the traveler’s behalf. These services include physician/dental/hospital referral, medical case monitoring, shipment of medical records and prescription medications, medical evacuation, repatriation of remains, and insurance/claims coordination.

**Medical Assistance:**

- Medical Referral
- Outpatient Assistance
- Inpatient Assistance
IMPORTANT NUMBERS

ELIGIBILITY, BENEFIT QUESTIONS
AND CLAIM STATUS, CONTACT:

Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647
Phone..............................................877-440-6840
Website..............www.maksin.com/nyack.aspx

• PLAN MANAGER

Collegiate Insurance Resources
172 Bechtel Road, Collegeville, PA 19426
Phone...............................................800-322-9901
Fax..................................................610-489-9325
Website..........www.cirstudenthealth.com/nyack

• TRAVEL ASSISTANCE/TRAVEL GUARD
Medical Evacuation, Lost Passports or
Luggage, etc.
Toll Free from U.S. and Canada..1-877-249-5362
Dial Direct or
Call Collect Worldwide.............1-715-295-9625

• STUDENT HEALTH SERVICES
Located in the Harold W. Boon
Campus Center.
Health Services is open M-F 9am to 4pm
(except during the summer)
Phone.............................................845-675-4576
Website..............www.nyack.edu/studentinsurance

• STUDENT COUNSELING CENTER
Located in the Harold W. Boon Campus Center
Appointments must be scheduled in advance.
Phone.............................................845-675-4563