STUDENT ACCIDENT INSURANCE PLAN

Designed for Undergraduate Students of:

NYACK

Rockland Campus
1 South Boulevard
Nyack, NY 10960

2013-2014

Policy Number USO 58784

Underwritten by:
United States Fire Insurance Company
INTRODUCTION
This brochure is a brief description of the Student Accident Insurance Plan for students at Nyack College (Rockland Campus) only. The exact provisions governing this insurance are contained in the Master Policy under Form AH27259 issued to Nyack College. The Master Policy shall control in the event of any conflict between the Policy and this brochure.

We suggest that you retain this brochure so you will have a ready reference to the benefits of the Plan. Any provision of the Policy or the brochure, which is in conflict with the statutes of the state in which the Policy is issued will be administered to conform with the requirements of such state statutes. Under HIPAA’s Privacy Rule We are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your insurance identification card.

POLICY TERM
Coverage begins at 12:01 AM August 1, 2013 and continues until 12:01 AM on August 1, 2014.

ELIGIBILITY
Nyack College sponsors the mandatory Student Accident Insurance Plan described in this brochure that is charged on the tuition bill for all full-time undergraduate students at the Rockland Campus. Coverage is in effect 24-hours a day on and off campus.

REFUND PROVISION
In the event a Covered Person leaves school to enter active military service, coverage will cease and a pro rata refund of premium will be made upon request, less any claims paid. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days. No other refund of premium will be allowed.
DEFINITIONS

“Accident” means a sudden and unforeseeable event which: (1) Causes Injury to one or more Covered Persons; and (2) Occurs while coverage is in effect for the Covered Person.

“Covered Person” means a person eligible for coverage for whom proper premium payment has been made and who is, therefore, insured under this Policy.

“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.

“Eligible Expense” means the Usual, Reasonable and Customary charges for services or supplies which are incurred by the Covered Person for the Medically Necessary treatment of Injury. Eligible Expenses must be incurred while this Policy is in force.

“Hospital” means a short-term, acute, general hospital which: (1) Is duly licensed by the agency responsible for licensing such hospitals; (2) 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; (3) Has organized department of medicine and major surgery; (4) Has a requirements that every patient must be under the care of a doctor or dentist; (5) Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.); (6) If located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861 (k) of United States Public Law 89-97 (42 USCA 1395X[k]; and 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; or

• 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 emergency basis; and (b) A legal liability exists for the charges made to the individual for the services given in the absence of insurance.

“Injury” means bodily harm that results, directly and independently of all other causes, from an Accident. All injuries to the same Covered Person sustained in one accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

“Medically Necessary” or “Medical Necessity” means the service or supply is: (1) Prescribed by a Doctor for the treatment of the Injury; and (2) Appropriate, according to conventional medical practice for the Injury in the locality in which the service or supply is given.

“Usual, Reasonable and Customary” means: (1) With respect to fees or charges, fees for medical services or supplies which are: (a) Usually charged by the provider for the service or supply given; and (b) The average charged for the service or supply in the locality in which the service or supply is received; or (2) With respect to treatment or medical services, treatment which is reasonable in relationship to the service or supply given and the severity of the condition.
DESCRIPTION OF BENEFITS

BASIC ACCIDENT BENEFITS

If as result of an Injury, including Injury resulting from intercollegiate sports, a Covered Person incurs Eligible Expenses, the Company will pay 100% of the Eligible Expenses within 52 weeks from the date of Accident, up to an aggregate maximum of $2,500 per Injury. The following Eligible Expenses will be considered: (a) treatment by a Doctor; (b) Hospital services; (c) services of a licensed practical nurse or R.N.; (d) X-ray service; (e) use of an operating room, anesthesia, laboratory service; (f) use of an ambulance; (g) use of an ambulatory medical center; or (h) if ordered by a Doctor, prescription medicines, drugs or any other therapeutic services or supplies. This includes benefits for treatment of Injury to sound, natural teeth.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If the Covered Person sustains any of the following losses as the result of a covered Accident, within 365 days after the date of Accident, the Company will pay the amount shown. “Member” means hand, foot or eye. Loss of a hand or foot means complete severance through or above the wrist or ankle joint. Loss of sight must be entire and irrecoverable. Loss of a thumb or index finger means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand). The Principal Sum of $5,000 is the largest amount payable under this benefit for all losses resulting from any one Accident.

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<th>For Loss of</th>
<th>Benefit</th>
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<tbody>
<tr>
<td>Life</td>
<td>$5,000</td>
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<tr>
<td>Two or more members</td>
<td>$5,000</td>
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<tr>
<td>One member</td>
<td>$2,500</td>
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MANDATED BENEFITS

This program also covers applicable mandated benefits as required by the State of New York.

EXTENSION OF BENEFITS

If a Covered Person is Totally Disabled on the date the Policy terminates, Eligible Expenses shall include charges incurred after the date of such termination with respect to Hospital Confinement that begins or Surgery performed during the next 31 days for the Injury or Sickness causing the Total Disability, subject to the applicable Maximum Amounts of this Policy. The Hospital confinement or Surgery must be only for the care and treatment of the Injury or Sickness which caused the Total Disability. 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.
EXCLUSIONS

The Policy would not cover nor provide benefits for:

1. 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; and
   (c) aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;

2. 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);

3. 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;

4. 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;

5. Eyeglasses, hearing aids, and examination for the prescription or fitting thereof;

6. Rest cures, custodial care and transportation.
CLAIM PROCEDURE

In the event of an Injury, the Covered person should:

1. Complete a claim form and mail it to A-G Administrators within 30 days of the date of the Injury or as soon thereafter as possible. Mail the claim form to: A-G Administrators, Inc. P.O. Box 979, Valley Forge, PA 19482 or fax to 610-933-4122.

2. Claim forms are available online at www.cirstudenthealth.com/nyack or by calling 1-800-752-2008. If the providers have given you bills, attach them to the claim form.

3. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to by calling A-G Administrators at 1-800-752-2008.

4. Itemized medical bills must be attached to the claim form at the time of submission. Subsequent medical bills received after the initial claim form has been submitted should be mailed promptly to A-G Administrators. No additional claim forms are needed as long as the Covered person’s name and identification number are included on the bill.

COORDINATION OF BENEFITS

The Policy pays primary, however, it will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverages under which the Covered Person is enrolled shall not exceed 100% of the R&C Charges for covered services.

SUBROGATION

When benefits are paid to or for a person under the terms of the policy, we shall be subrogated, unless otherwise prohibited by law, to the rights of recovery of such person against any person who might acknowledge liability or found legally liable by a Court of competent jurisdiction for the injury that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by us of the benefits we have paid for such hospitalization and treatment and we shall pay fees and costs associated with such recovery.

The person agrees to sign papers and do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf. He further agrees to furnish us with all relevant information and documents.