

DAVIS COLLEGE - 2009-2010 STUDENT ACCIDENT & SICKNESS PROGRAM
Administrator Policy #AMH0043200 / Underwriter Reference #CASS9710338

The following is a brief description of an Accident and Sickness Insurance Program designed for students attending Davis College ("the Policyholder"). The Master Policy issued to the College contains the complete details of coverage and is the governing document. It may be inspected during normal business hours at the Student Health Service. The Student Sickness & Accident Policy is underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. ("the Company") with its principal place of business in New York, New York.

ELIGIBILITY: All students formally enrolled in a full-time course of study leading to a degree are eligible to enroll in this insurance plan. Matriculated students, enrolled from between 6 and 11 credits, are also eligible to purchase the Policy.

A Covered Student may enroll dependents (the Covered Student's spouse and the Covered Student's unmarried children up to age 19 who are not self-supporting). To obtain a dependent enrollment form, visit the Student Health Service. All premiums must be paid by check or money order.

TERM OF COVERAGE: Coverage begins 12:01 AM on August 28, 2009 and terminates 11:59 PM on August 27, 2010. Except for medical withdrawal due to a covered injury or sickness, any student withdrawing from the College during the first thirty-one (31) days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid, and no refund will be allowed. 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.

OPEN ENROLLMENT: Premium for each enrollment period must be received within 31 days from the effective date of the enrollment period. However, a student who does not enroll during an Open Enrollment Period may not apply for coverage until the next Open Enrollment Period unless an application is made within 31 days of the following qualifying events: 1) Birth/adoption; 2) Marriage; and 3) Loss of benefits due to spouse's parent's loss of employment. An eligible student may enroll for coverage for his or her Dependents only within the 31 days immediately following the beginning of each Policyholder's term of coverage; or within 31 days of marriage, birth, or adoption.

BASIC ACCIDENT & SICKNESS BENEFITS

For Accidents

When injury, including injury resulting interscholastic sports (other than interscholastic football, ice hockey or lacrosse), requires treatment, payment will be made up to a maximum benefit of \$2,000, subject to a \$30 deductible, for covered medical expense resulting from each accident occurring during the term insured. Covered medical expenses are those expenses for doctors, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other reasonable and customary medical expense incurred while insured under the Policy. Injuries to sound, natural teeth are covered on the same basis as any other injury. For use of an emergency room a \$50 per visit copay will apply. The \$30 deductible is waived when services are provided at the Student Health Service or when a referral is made by a Student Health Service doctor.

For Sickness

When hospital or medical care is required for sickness including mental and nervous conditions, first manifesting during the term insured, payment will be made as allocated below for covered medical expense not to exceed \$2,000 for any one Sickness under this Benefit. Maternity expense and complications of pregnancy, conception occurring during the term insured, biologically based mental illness/serious emotional disturbances, are covered on the same basis as Sickness. A voluntary or elective abortion is covered only as specifically provided.

Hospital Room and Board Expense: The semi-private room rate, up to \$300 per day when hospitalization is Medically Necessary and ordered by an attending doctor.

Miscellaneous Hospital Expense: Up to \$1,000 for X-ray examinations and laboratory tests, including professional fees, anesthesia, medicines, use of operating room, oxygen tent, drugs (excluding take home drugs), medicines, dressings and other necessary and prescribed miscellaneous hospital expense when the Covered Person is confined as a bed patient in a hospital, or as an outpatient for day surgery.

Pre-Admission Test Expense: Up to \$500 for hospital outpatient expense for tests ordered by a doctor which are required prior to admission as an inpatient for surgery.

Surgeon Expense (in or out of hospital): Up to 80% of Reasonable and Customary charges to a maximum of \$1,500.

Anesthesia: not to exceed 20% of the amount payable for the surgery. **Assistant Surgeon:** not to exceed 20% of the amount payable for the surgery.

Second Surgical Opinion Expense: Up to 5% of the surgical maximum will be paid for a second opinion consultation by a board certified specialist in the medical field related to the surgical procedure to be performed. Payable expense includes X-rays and diagnostic tests.

Doctor's Expense (when hospital confined): Up to \$20.00 per visit for hospital visits, limited to one visit per day. The doctor may not be the surgeon who operated on you.

Doctor's Expense (when not hospital confined): Up to \$35.00 per visit for outpatient services, beginning with the third visit, not to exceed 5 visits, limited to one visit per day. The doctor may not be the surgeon who operated on you. Benefits begin with the first visit if: (1) the student is seen by the Student Health Service and then referred, (2) the sickness is such that emergency treatment is necessary and the Student Health Service is closed or, (3) the student is away from the College for any reason. A \$5.00 per visit copay will apply to conditions 2 and 3. Only one visit per sickness is payable under condition 2.

Consultant Expense: Up to \$125 for the services of a consultant or specialist when such services are deemed necessary and ordered by a Student Health Service doctor, or Athletic Trainer for the purpose of confirming or determining a diagnosis. The attending doctor must order such services for dependents.

Ambulance Expense: Up to \$35.00 for an ambulance when such transportation is required due to the emergency nature of a sickness.

Outpatient Expense: Up to \$300, subject to a \$25.00 deductible, for outpatient X-rays, laboratory tests and the use of an emergency or operating room used for non-scheduled surgeries (the \$25 deductible does not apply to the use of an emergency room; however, a \$50 per visit copay will apply). The \$25 deductible is waived when (1) services are provided at the Student Health Service; (2) a referral is made by a Student Health Service doctor or by an attending doctor for dependents and students when the College is not in session.

CAT Scan, MRI and Similar Procedures: Up to \$1,500 for CAT scans and Magnetic Resonance Imaging when recommended by an attending doctor.

Prescribed Medicine Expense: Up to \$100 per sickness for prescribed drugs and medicines per semester. A \$5 per prescription copay will apply. However, obtained, all Outpatient Prescription Drugs are subject to the Outpatient Prescription Drug Maximum.

Dental Expense: Up to \$50.00 per tooth on an inpatient basis and \$25.00 per tooth on an outpatient basis for the removal of impacted wisdom teeth and dental abscesses. No other Policy benefits are payable.

Abortion Expense: Up to \$250 for expense resulting from an abortion, conception occurring during the term insured. No other Policy benefits are payable.

Outpatient Mental and Nervous Condition Expense: Up to 50% of the charges not to exceed \$30.00 per visit beginning with the third visit, for treatment by a doctor while not hospital confined. Benefits will begin with the first visit if the student is referred by either the Director of Student Health or Director of Counseling. The maximum amount payable under this benefit is \$900 each policy year. (No benefits are paid for prescription drugs related to outpatient treatment of mental and nervous conditions.)

Accidental Death and Dismemberment Indemnity: If the Covered Person sustains any of the following losses as the result of a covered accident, within 26 weeks 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 an eye means the total, permanent loss of sight in the eye. 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 \$7,500 is the largest amount payable under this benefit for all losses resulting from any one accident.

Life.....	\$7,500	One member.....	\$3,750
Two or more members.....	\$7,500	Thumb and index finger of the same hand.....	\$1,500

Home Health Care Benefit: If the Covered Person requires any of the home health care services listed below as the result of a covered injury or sickness, directly and independently of all other causes, the Company will pay the benefits shown for expense incurred within the policy year. Part-time intermittent nursing care by (or supervised by) a Registered Nurse (R.N.), Part-time or intermittent patient care services by a home health care aide, Physical, occupational speech, or respiratory therapy provided by a Home Health Care Agency, Medical supplies, drugs and medications, and laboratory services, but only to the extent these benefits would be covered if the patient was confined in a Hospital. The amount of this benefit is 75% of the Reasonable and Customary Charges for the above services made by a Home Health Care Agency, minus a deductible of \$50 per Policy year. This benefit is payable only if the home health care plan is set up and approved in writing by the attending doctor. This benefit will not pay for more than 40 home health care visits in any period of 12 straight months. "Visit" means a maximum of four (4) continuous hours of home health service.

Outpatient Alcoholism and Substance Abuse Expense: The Company will pay for outpatient covered expenses incurred by the Covered Person for the diagnosis and treatment of alcoholism or substance abuse. This benefit covers up to 60 visits in any Policy year for the Covered Person, including up to 20 visits for a Covered Person's family members. If covered under the Policy as dependents. Only one outpatient visit a day is covered. Treatment or services must be provided at a facility in New York State certified by the office of alcoholism and substance abuse services or licensed by such office as outpatient clinics or medically supervised ambulatory substance abuse programs; or, in other states, those facilities accredited by the Joint Commission on accreditation of Hospitals as alcoholism or chemical dependence treatment programs.

Incident Care for Alcoholism and Substance Abuse: The Company will pay for the diagnosis and treatment of alcoholism or alcohol abuse and substance abuse or substance dependence, to the extent provided below: (1) For detoxification, inpatient service in a Hospital or Residential Treatment Facility, up to seven days of detoxification treatment in any Policy year, and; (2) For rehabilitation service, up to thirty days of inpatient care in any Policy year. Treatment or service must be provided by a Hospital or Residential Treatment Facility.

Diabetes Equipment, Supplies and Service-The Company will pay the Reasonable and Customary charges incurred for such supplies and service less a deductible of \$25 per Policy year. We will also pay the Reasonable and Customary charges for Diabetes self-management and education.

SUPPLEMENTAL ACCIDENT & SICKNESS BENEFITS

Payment will be made for eighty percent (80%) of covered medical expense incurred for an injury or sickness in excess of \$2,000, to a maximum payment of an additional \$23,000 payable under this Benefit for each accident or sickness. Covered medical expense are those expenses for doctors, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other Reasonable and Customary medical expense incurred while insured under the Policy.

THIS PROGRAM ALSO COVERS MANDATED BENEFITS AS REQUIRED BY THE STATE OF NEW YORK.

DEFINITIONS

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

"Totally Disabled" and **"Total Disability"** means Injury or Sickness which wholly and continuously keeps the Covered Person, (a) with respect to a student, from attending classes at the location where he or she is enrolled; and (b) with respect to a dependent, or a student if such classes are not in session, from doing those activities that are normal for a person in good health of the same age and sex.

"Injury" means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other cause; (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.

"Medically Necessary" means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. 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. 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, or (d) it can be safely provided to the patient on a more cost-effective basis such as out-patient, by a different medical professional or pursuant to a more conservative form of treatment.

"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 which is the smallest of: (a) the actual charge; (b) the charge of similar professional standing by the provider who furnishes it; and (c) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.

COORDINATION OF BENEFITS: Benefits are for Accidents and Sickness and Sickness are coordinated with other health insurance you may have in force as described in the Policy.

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

(1) 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, and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy. This exclusion shall not apply to cosmetic surgery determined, as a result of utilization review and External Review, to be Medically Necessary; (2) Suicide attempted suicide or intentionally self-inflicted Injury or any attempted intentionally self-inflicted Injury; (3) Travel as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline; (4) Foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; (5) Care or treatment provided in a government Hospital; benefits provided under Medicare or other governmental program (except Medicaid); (6) Care or treatment for which benefits are provided under any state or Federal Workers' Compensation, employers' liability or Occupational Disease Law; (7) A motor vehicle Accident for which benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable; (8) Services rendered and separately billed by employees of Hospitals, laboratories or other institutions; (9) Any services rendered by a Covered Person's immediate family member; (10) Services for which no charge is normally made; (11) For eyeglasses and examination for the prescription or fitting thereof; (12) Hearing aids and examination for the prescription or fitting thereof; (13) Custodial care and transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities; (14) Rest cures; (15) War or act of war (whether declared or undeclared); (16) Service in the Armed Forces or units auxiliary thereto. Upon the Covered Person entering the Armed Forces or units auxiliary thereto of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for the Policy; (17) Participation in a felony, riot or insurrection; (18) Treatment of mental or emotional disorders except as provided under the Policy; (19) Any care or treatment not related to the treatment of Sickness or Injury.

PRE-EXISTING CONDITIONS: Pre-existing conditions are not covered for the first 12 months following a Covered Person's effective date of coverage under the Policy. This limitation will not apply if: 1) the Covered Person has been covered under the Policyholder's prior Policy for more than 12 consecutive months; or 2) (a) The individual seeking coverage under the Policy has a total of 12 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage. We will credit the time the individual was covered under prior Creditable Coverage; and (b) whose most recent prior Creditable Coverage was under an employer group health plan; and (c) who accepted and used up COBRA continuation of coverage or similar state coverage if it was offered to him or her.

EXTENSION OF BENEFITS: If, on the date coverage terminates, a Covered Person is Totally Disabled as a result of Sickness or Injury and is receiving treatment for such Sickness or Injury, benefits will be payable for the Eligible Expenses incurred for that Sickness or Injury after the date coverage terminates until the earliest of the following: (1) the end of the Sickness or Injury that caused the Total Disability; (2) the end of the 90 day period following the date coverage terminated; or (4) the date the applicable Maximum Amount is reached. **IN THE EVENT OF PREGNANCY.** If a Covered Person is pregnant on the date the Policy terminates and the pregnancy commenced while Insured while this Policy was in force, benefits will be payable for Eligible Expenses incurred 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.

CLAIM PROCEDURE In the event of Accident or Sickness the student should: If at the College, report immediately to Student Health Services so that proper treatment can be prescribed or approved; or if away from the College, consult a doctor and follow his or her advice.

(1) Notify Student Health Services or Maksin Management Corp., within 30 days after the date of the covered accident or commencement of the covered sickness or as soon thereafter as is reasonably possible; (2) Secure a claim form from the Student Health Services or Maksin Management Corp.; (3) Complete the form; (4) Submit the claim form, complete with bills and receipts, to the Student Health Services or Maksin Management Corp.; (5) Submit only one claim form for each accident or sickness. NOTE: Notification of sickness or accident must be furnished within 30 days after the date of accident or commencement of sickness. Bills for which benefit are to be paid must be submitted within 90 days.

Questions regarding enrollment, benefits, a specific claim and periods of coverage should be directed to:

Maksin Management Corp.
P.O. Box 2647 Camden, NJ 08101-2647
(877) 775-5430 / www.maksin.com

Local Representative:
Pheps Agency, Inc.
Southern Tier Agency Associates
PO Box 1030, Binghamton, NY 13902-1030
Phone: (607) 723-5413 / Fax: (607) 771-0679

Note: The time you were covered under this program may count as creditable coverage under State and Federal Law if you leave this program and become covered under a group health plan or other plan within 63 days after coverage under the Policy terminates. You are eligible to receive a certification from the Company regarding the periods you were covered. Please contact the Local Representative listed in this flyer when you need such certification.

	Annual Premium August 29, 2009-August 27, 2010	Spring/Summer - January 15, 2010-August 27, 2010
STUDENT	\$ 697.00	\$ 466.00
SPOUSE	\$1,742.00	\$ 1,165.00
CHILD(REN)	\$1,045.00	\$ 697.00

DISCLAIMER: This is only a brief description of the coverage available under policy series S30494NUFKC. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between contents of this document and the Policy, the Policy shall govern in all cases. The Policy is on file for review at Davis College. It is the Covered Student's responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.