

Student Injury and Sickness Insurance Plan

**Designed Especially
For The Students Of**



ROCKHURST
A Jesuit University

KANSAS CITY, MO

2009 - 2010

UNDERWRITTEN BY:
United States Fire Insurance Company
by Fairmont Specialty
a Division of Crum & Forster
Eatontown, NJ 07724

**Policy # US003674
Group # 09430023**

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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 or former 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 policy through your school, or by calling us toll-free at 1-877-246-6997 or by visiting us at www.summitamerica-ins.com.

ELIGIBILITY

Students enrolled in the insurance plan must actively attend classes for at least the first 31 calendar days after the date for which coverage is purchased. Home study, correspondence, Internet and television (TV) courses do not fulfill the Eligibility Requirements that the Student actively attend classes. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Full-Time Undergraduates & Full-Time Graduate Students

All full-time undergraduate domestic students taking 12 or more credit hours and all full-time graduate students taking 9 or more credit hours are required to purchase this insurance plan, unless proof of comparable coverage is supplied by the waiver deadline of August 28, 2009, for the fall semester, or January 29, 2010, for transfer and new students beginning in the spring semester. The cost of the insurance plan will automatically be charged to the student's account unless proof of comparable coverage is furnished by the waiver date. To waive the insurance plan, please visit www.summitamerica-ins.com. Students in the DO/MBA, Executive MBA and Accelerated Option programs are exempt from this requirement.

International Students/Scholars

International students/scholars are required to purchase this insurance plan, and the cost of the insurance plan will automatically be charged to the student's account.

All Other Students

Enrollment in this insurance plan is optional. Students in the DO/MBA, Executive MBA, Accelerated Option programs and part-time students are eligible to enroll in the insurance plan on a voluntary basis. Visit www.summitamerica-ins.com to enroll online, or contact Summit America at 800-955-1991.

Dependents

Eligible students who enroll may also insure their Dependents at www.summitamerica-ins.com. Eligible Dependents are the spouse and unmarried children under 19 years of age or 25 years if a full-time student at an accredited institution of higher learning who are not self-supporting. Dependent Eligibility

expires concurrently with that of the Insured student.

EFFECTIVE AND TERMINATION DATES

Annual.....8/15/2009 to 8/15/2010
Fall.....8/15/2009 to 1/18/2010
Spring/Summer.....1/19/2010 to 8/15/2010

The Master Policy on file at the school becomes effective August 10, 2009. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates August 15, 2010. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Insured student athletes who are members of and are participating in intercollegiate sports sponsored by Rockhurst University (baseball, softball, basketball, volleyball, soccer, cheerleading, golf, or tennis) are covered effective August 10, 2009 to August 10, 2010.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the university expiration date.

Refunds of premiums are allowed only upon entry into the armed forces.

The Policy is a Non-Renewable, One-Year Term Policy.

PRE-EXISTING CONDITIONS LIMITATION

“Pre-existing Condition” is a Sickness, Injury, or related condition for which a licensed Doctor was consulted; or for which treatment or medication was prescribed within twelve (12) months prior to the Effective Date of the Insured Person’s coverage under this Policy.

The Pre-existing Condition Waiting Period is twelve (12) months. If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student’s effective date, and (b) We will pay only for Loss or expense incurred after such twelve (12) consecutive month period.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage, the Pre-existing Condition Waiting Period will have to be satisfied again.

COORDINATION OF BENEFITS

Benefits will be coordinated with any other group medical, surgical or hospital plan so that combined payments under all programs will not exceed 100% of charges incurred for covered services and supplies.

EXTENSION OF BENEFITS AFTER TERMINATION

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the 90 day period following such termination of insurance.

ADDITIONAL BENEFITS

Mammographic Examination Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for mammographic exams. The charges must be incurred while the Insured Person is insured for these benefits.

Benefits will be paid for mammographic exam charges incurred for the following:

- (a) One baseline Mammogram for a woman thirty-five through thirty-nine years of age;
- (b) One Mammogram every twenty-four months for a woman forty through forty-nine years of age, inclusive, or more frequently upon recommendation of a Doctor;
- (c) One Mammogram every twelve months for a woman fifty years of age or older;
- (d) A Mammogram for any woman, upon the recommendation of a Doctor, where such woman, her mother or her sister has a prior history of breast cancer.

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

"**Mammogram**" means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes specifically for mammography that delivers an average radiation exposure of less than one rad mid-breast with two views for each breast. The term includes the professional interpretation of the film.

Pelvic, Cervical, Prostate and Colorectal Exam Expense Benefit

We will cover the Covered Percentage of Covered Charges for Expenses incurred for all of the following examinations:

- (a) an annual pelvic examination and pap smear for any non-symptomatic female Insured Person; and
- (b) an annual prostate examination and laboratory tests for any non-symptomatic male Insured Person; and
- (c) an annual colorectal cancer examination and laboratory tests for any non-symptomatic Insured Person.

All examinations and laboratory tests must be performed in accordance with the current guidelines established by the American Cancer Society.

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

(Additional Benefits continued)

Child Immunization Expense Benefit

We will pay the Covered Charges incurred for immunizations of a covered Dependent child from birth to five (5) years of age. We cover such charges the same way We treat Covered Charges for any other Sickness, except Covered Charges for this benefit are not subject to any Deductible or Copayment provisions.

Dental Anesthesia and Hospitalization Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for the administration of general anesthesia and Hospital charges for dental care provided to an Insured Person who:

- (a) is a child under the age of five (5); or
- (b) is severely disabled; or
- (c) a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

Treatment may be provided by a dentist in either a Hospital, surgical center, or office.

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

Enteral Formula Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for a formula or formulas recommended by a Doctor for the treatment of an Insured Person with phenylketonuria or any inherited disease of amino or organic acids.

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

Breast Reconstruction After Mastectomy Expense Benefit

If an Insured Person who is receiving benefits under the Policy in connection with a mastectomy elects breast reconstruction in connection with such mastectomy, Covered Charges include those incurred for:

- (a) reconstruction of the breast on which the mastectomy was performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prostheses and treatment for physical complications from all stages of the mastectomy, including lymphedemas, in a manner determined by the attending Doctor and the Insured Person.

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

Newborn Hearing Screening Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification for a newborn Dependent.

We cover such charges the same way We treat Covered

(Additional Benefits continued)

Charges for any other Sickness.

Osteoporosis Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for diagnosis, treatment and appropriate management of osteoporosis for Insured Persons with a condition or medical history for which bone mass measurement is medically indicated. In determining whether testing or treatment is medically appropriate the Doctor shall give due consideration to peer reviewed medical literature.

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

Maternity Expense Benefit

We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital. The Doctor's approval to discharge must be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization.

For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child who have a shorter Hospital stay, We will pay for post-discharge care to the mother and her newborn. Post-discharge care will consist of two visits by a Doctor or a registered professional nurse with experience in maternal and child health nursing. The location and schedule of the visits will be determined by the Doctor. One visit must be in the Insured Person's home. Services may be provided in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or other nationally recognized medical organization.

Newborn Infant Care – Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is

(Additional Benefits continued)

affiliated with or practicing in conjunction with a licensed facility.

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

Chemical Dependency and Mental Illness

Expense Benefit

A. Covered Charges for Treatment of Chemical Dependency

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of Chemical Dependency on the same basis as for any other Sickness, subject to the following limits:

1. Outpatient treatment through a Nonresidential Treatment Program or through partial- or full-Day Program Services, up to 26 days per Policy Year.
2. Residential Treatment Program, up to 21 days per Policy Year.
3. Medical and Social Setting Detoxification, up to 6 days per Policy Year.
4. Lifetime limit of 10 Episodes of treatment per Insured Person, except that this frequency maximum will not apply to Medical Detoxification in a life-threatening situation as determined by the treating Doctor and subsequently documented within 48 hours of treatment to our reasonable satisfaction.

B. Covered Charges for Treatment of Recognized Mental Illness

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary care and treatment of Recognized Mental Illness (excluding Chemical Dependency) to the same extent as any other covered Sickness for the following services:

1. Outpatient treatment, including treatment through partial or full-Day Program Services, for mental health services rendered by a licensed professional.
2. Residential treatment programs for therapeutic care when prescribed by a licensed professional and rendered in a psychiatric Residential Treatment Center.
3. Inpatient Hospital treatment, up to 90 days per Policy Year.

We may administer the above Covered Charges through a Managed Care Program established by Us. Covered services may be delivered through a system of contractual arrangements with one or more providers, Hospitals, Nonresidential or Residential Programs or other mental health service delivery entities certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization or licensed by the state of Missouri.

C. Covered Charges for Other Mental Health Benefits

We will pay the Covered Percentage of the Covered Charges incurred for two sessions per Policy Year with a licensed psychiatrist, licensed psychologist, licensed professional counselor or licensed clinical social worker who is acting within the scope of such license on the same basis as for any other Sickness, subject to the following:

1. Care must be for the purpose of diagnosis or assessment, but not dependent upon findings;
2. Services are not subject to prior approval, pre-

(Additional Benefits continued)

- authorization or pre-certification and are reimbursable as long as the provisions of this benefit are satisfied;
3. Benefits are subject to the same Coinsurance, Copayment and Deductible factors of the Policy that apply to regular office visits for physical Sickness.

“Chemical Dependency” means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.

“Community Mental Health Center” means a legal entity certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.

“Day Program Services” means a structured, intensive day or evening treatment or partial hospitalization program, certified by the Missouri Department of Mental Health or accredited by a nationally recognized organization.

“Episode” means a distinct course of Chemical Dependency treatment separated by at least 30 days without treatment.

“Licensed Professional” means a licensed Doctor specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor.

“Managed Care” means the determination of availability of coverage through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, some involving case management.

“Medical Detoxification” means Hospital inpatient or residential medical care to ameliorate acute medical conditions associated with Chemical Dependency.

“Nonresidential Treatment Program” means a program certified by the Missouri Department of Mental Health involving structured, intensive treatment in a nonresidential setting.

“Recognized Mental Illness” means those conditions classified as “mental disorders” in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. It does not include mental retardation.

“Residential Treatment Program” means a program certified by the Missouri Department of Mental Health involving residential care and structured, intensive treatment.

“Social Setting Detoxification” means a program in a supportive nonhospital setting designed to achieve detoxification, without the use of drugs or other medical intervention to establish a plan of treatment and provide for medical referral when necessary.

Early Intervention Services Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Early Intervention Services that are delivered by early intervention specialists who are health care professionals licensed by the State of Missouri and acting within the scope of their licenses for children from birth to age three. Such coverage shall be limited to \$3,000 for each covered child per Policy Year and a maximum of \$9,000 per child.

“Early Intervention Services” means medically necessary speech and language therapy, occupational therapy, physical

(Additional Benefits continued)

therapy and assistive technology devices for children from birth to age three with a disability as identified by an individualized family service plan team in any one or more of the following areas:

- (a) physical development; (b) cognitive development;
- (c) communication development; (d) social or emotional development; or (e) adaptive development.

Chiropractic Care Expense Benefit

In addition to the above, chiropractic care is mandated and covered up to the maximum shown in the Schedule of Benefits.

CONTRACEPTIVE BENEFIT

The policy provides benefits for contraceptive drugs or devices. If for moral, ethical or religious beliefs, you do not want benefits for contraceptive drugs or devices contact the agent, Summit America Insurance Services, at 800-955-1991.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

The Principal Sum is \$10,000.

When, because of an Injury, the Insured Person suffers any of the following Losses within 180 days from the date of the Accident, We will pay as follows:

For Loss Of:

Life.....	\$10,000
Two hands	\$10,000
Two feet.....	\$10,000
Sight of two eyes.....	\$10,000
One hand and one foot	\$10,000
One hand and sight of one eye	\$10,000
One foot and sight of one eye	\$10,000
One hand or one foot or one eye.....	\$5,000
Thumb and Index Finger of Either Hand.....	\$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. Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.

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:

- (1) By 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 the Policy;
- (2) By an infection, unless it is caused solely and independently by a covered Accident or if it is a bacterial infection resulting from the accidental ingestion of contaminated substances;
- (3) For Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a

felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or

(4) While the Insured Person is legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.

In addition to the above, this provision is subject to the Exclusions as provided.

HEALTH SERVICES FOR ROCKHURST UNIVERSITY AND RESEARCH COLLEGE OF NURSING STUDENTS

Health Services for Rockhurst University students are provided by Goppert Trinity Family Care located at 6650 Troost, Suite 201, Kansas City, MO 64131, (816) 276-7600. Appointment times include standard business hours as well as most early evenings. On-site services include board certified family physicians, lab, x-ray, minor surgical suites, and Stark Pharmacy to fill prescriptions. Students who have the Rockhurst University sponsored health insurance obtain services at Goppert at the highest level of benefit (please see the schedule of benefits on pages 10-11).

For emergency after-hours health care needs outside of Goppert's normal hours of operation, students are encouraged to contact the resident physician on call for Goppert at (816) 276-7600 or the pager number is (816) 435-0884. If a student needs immediate emergency treatment, they are encouraged to call Security (816) 501-4911 or go to the closest emergency room. Research Hospital – Brookside Campus emergency room is located next to Goppert and is often most convenient (6601 Rockhill Road).

The Deductible, Copay and Coinsurance will be waived if treated by Goppert. Immunizations are covered at Goppert only; there is no coverage for immunizations from any other provider.

ID CARDS

To obtain an insurance plan ID card please visit the Student Development website at www.rockhurst.edu. From there you will be able to view and print an ID card, brochure, enrollment forms and frequently asked questions.

For additional plan materials or information, contact Summit America Insurance Services at 800-955-1991.

INTERCOLLEGIATE SPORTS MAXIMUM BENEFIT

\$5,000 (FOR EACH INJURY PER POLICY YEAR)

Benefits will be paid under the Schedule of Benefits for intercollegiate sports Injury up to \$5,000 for each Injury per policy year.

SCHEDULE C

The Policy provides benefits for the Usual, Reasonable and Customary Charges incurred by an Insured (see page 12 for information on the Preferred Provider Network) any Covered Medical Expenses will be paid. If the Covered Medical Expenses are incurred at a Preferred Provider, the benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Medical Expenses are incurred at an Out-of-Network Provider, the benefits will be reduced, or lower benefits will be provided when an Out-of-Network Provider is used.

The Deductible, Copays and Coinsurance Percentage will be waived if treated by Goppert.

Maximum Benefit for each Injury or Sickness.....

Deductible per Insured Person per Policy Year (waived if treated at Goppert).....

COVERED MEDICAL EXPENSES:

Doctor's Visits, benefits are limited to one visit per day. Benefits for Doctor's Visits do not apply when related to surgery or Physiotherapy. **Copay, coinsurance and deductible waived at Goppert**.....

Hospital Expense, daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia drugs (except take home drugs) or medicines, therapeutic services and supplies. In computing the number of days payable for this benefit, the date of admission will be counted, but not the date of discharge.

Consultant Doctor Fees, when requested and approved by the attending Doctor

Surgeon's Fees, in accordance with data provided by Ingenix. When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure. In computing the number of days payable under Multiple Surgical Procedures performed during the same operation, different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge for the Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount not less than the Covered Percentage of the Covered Charge for these procedures.

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, Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge.

Anesthetist, professional services in connection inpatient or outpatient surgery

Registered Nurse's Services, private duty nursing care

Pre-Admission Testing, this benefit is payable within 3 working days prior to admission.....

Outpatient Miscellaneous Benefit, includes benefits designated as Paid under Outpatient Miscellaneous Benefits.....

Tests & Procedures, diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits, Physiotherapy, x-rays and lab procedures.

CAT Scan / MRI.....

Physiotherapy, Outpatient benefit only. Benefits are limited to one visit per day, 26 visits per year.....

Medical Emergency Expense, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness.

Radiation Therapy / Chemotherapy

Prescription Drugs, using the Script Care Pharmacy Network only. (Includes contraceptives)

Injections, when administered in the Doctor's office and charged on the Doctor's statement.....

Ambulance Services.....

Durable Medical Equipment, a written prescription must accompany the claim when submitted. Replacement equipment is not covered.

Dental Treatment, made necessary by Injury to Natural Teeth.....

Chiropractic Services.....

Mental Illness (Inpatient benefits are limited to one visit per day).....

Alcoholism / Chemical Dependency.....

Maternity & Routine Newborn Care, while Hospital confined; and routine nursery care provided immediately after birth.....

Intercollegiate Sports

Physical Wellness Exam

Immunizations, including meningitis and HPV

Pathogen Exposure

OF BENEFITS

Person for loss due to a covered Injury or Sickness. If care is received from a Preferred Provider (see d at the Preferred Provider level of benefits. If a Preferred Provider is not available in the Network Area, al Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level provider is used. Benefits will be paid up to the Maximum Benefit for each service as scheduled below. **Trinity Family Care. Covered Medical Expenses incurred at Goppert are paid at 100%.**

	Preferred Provider	Out -of-Network
	\$50,000	\$50,000
	\$150	\$150
	80% of Preferred Allowance /	60% of URC /
	\$25 copay per Outpatient visit	\$25 deductible per Outpatient visit
aneous	80% of Preferred Allowance /	60% of URC /
cluding	\$1,000 maximum per day	\$1,000 maximum per day
under		
	80% of Preferred Allowance	60% of URC
al	80% of Preferred Allowance /	60% of URC /
cedure being performed.....	\$2,000 maximum per day	\$2,000 maximum per day
erative session but through		
arge of the most expensive		
ount equal to 50 percent of		
erating room;	80% of Preferred Allowance /	60% of URC /
plies. (Reasonable.....	\$4,000 maximum per day	\$4,000 maximum per day
Index.)		
	80% of Preferred Allowance	60% of URC
	80% of Preferred Allowance	60% of URC
	80% of Preferred Allowance	60% of URC
fit.	80% of Preferred Allowance /	60% of URC /
	\$3,000 maximum per Policy Year	\$3,000 maximum per Policy Year
	Paid Under Outpatient Misc.	Paid Under Outpatient Misc.
	Paid Under Outpatient Misc.	Paid Under Outpatient Misc.
	Paid Under Outpatient Misc.	Paid Under Outpatient Misc.
	Paid Under Outpatient Misc.	Paid Under Outpatient Misc.
	Paid Under Outpatient Misc.	Paid Under Outpatient Misc.
	\$10 copay for generic / \$30 copay for brand names / \$500 maximum per Policy Year	No Benefit
	80% of Preferred Allowance	60% of URC
	80% of URC	80% of URC
	80% of URC	80% of URC
	80% of URC	80% of URC
	Paid as Outpt Dr. Visit, 26 visits per policy year	Paid as Outpt Dr. Visit, 26 visits per policy year
	See Chemical Dependency and Mental Illness Expense Benefit, pages 5-7	
	See Chemical Dependency and Mental Illness Expense Benefit, pages 5-7	
ter birth.....	See Maternity Expense Benefit, page 4	See Maternity Expense Benefit, Page 4
	Paid as any other Injury	Paid as any other Injury
	\$5,000 maximum per Policy Year	\$5,000 maximum per Policy Year
	Covered 100% at Goppert	\$100 maximum per Policy Year
	Covered 100% at Goppert	No Benefit
	\$1,500 maximum per Policy Year	\$1,500 maximum per Policy Year

* URC means Usual, Reasonable & Customary

PREFERRED PROVIDER INFORMATION

“**Preferred Providers**” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in your local school area are: hospitals and physicians participating in the First Health Network.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-888-685-7774, visiting the website at www.firsthealth.com and/or by asking the provider when making an appointment for services.

“**Preferred Allowance**” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

“**Out of Network**” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured’s responsibility.

“**Network Area**” means the 50 mile radius around the local school campus the Named Insured is attending.

Inpatient Hospital Expenses

PREFERRED HOSPITALS - Eligible inpatient Hospital expenses at a Preferred Hospital will be paid at 80%, up to any limits specified in the Schedule of Benefits, up to any limits specified in the Schedule of Medical Expense Benefits. Call (888) 658-7774 for information about Preferred Hospitals.

OUT OF NETWORK HOSPITALS - If care is provided at a Hospital that is not a Preferred Provider, eligible inpatient Hospital expenses will be paid according to the benefit limits in the Schedule of Medical Expense Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount your bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amount that exceeds the Benefits shown on the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by the First Health Network will be paid at the coinsurance shown in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Medical Expense Benefits.

SCRIPT CARE PRESCRIPTIONS

When you use a Script Care network pharmacy, you will be able to get up to a 30 day supply of drugs prescribed for a Covered Injury or Sickness. Go to www.scriptcare.com to find a network pharmacy in your area. You will pay a \$10 copayment for each generic drug and a \$30 co payment for each brand name drug not to exceed the \$500 per policy year benefit maximum. Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

(Script Care Prescriptions continued)

If you do not present the card, you will need to pay the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please call Script Care Customer Service line toll free at 1- 800-880-9988, www.scriptcare.com.

DEFINITIONS

“**Accident**” means a specific unforeseen event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

“**Coinsurance**” means the percentage of Usual, Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

“**Complications of Pregnancy**” means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- acute nephritis or nephrosis; and
- cardiac decompensation or missed abortion; and
- similar medical and surgical conditions of comparable severity; and
- non-elective caesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible.

(This does not include voluntary abortion.)

Not included are: (a) false labor, occasional spotting or doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and preeclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

“**Copayment**” means the specified dollar amount an Insured Person must pay for specified charges. The copayment is separate from and not a part of the Deductible or Coinsurance.

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

“**Covered Percentage**” means that part of the Covered Charge that is payable by the Company after the Deductible or Copayment has been met.

“**Deductible**” means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

“**Dependent**” means: (a) the Insured Student’s spouse

(Definitions continued)

residing with the Insured Student; or (b) the Insured Student's unmarried Children under the age of nineteen years or to age 25, if they are full-time students at an accredited school. Children must be fully supported by the Insured Student. Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth. To continue the newborn child's dependent benefits past the first 31 days, the Insured Student must notify Us in writing within 31 days of the child's birth.

The term "**children**" includes an Insured Student's biological children and step-children who depend on the Insured Student for their full support.

Adopted children of the Insured Student are covered on the same basis as other Dependent children: (a) from the date of birth if a petition for adoption is filed within 30 days of the birth of such child; or (b) from the date of placement for the purpose of adoption if a petition for adoption is filed within 30 days of placement of such child. Such coverage shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treatment of medical conditions existing prior to the date of placement. As used here, "placement" means in the physical custody of the adoptive Insured Student.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

Within 31 days after the child reaches the age limit, the Insured Student must send us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.

"**Doctor**" means a licensed practitioner of the healing arts acting within the scope of his license. **Doctor** does not include: You; Your spouse, dependent, parent, brother, or sister; or A person who ordinarily resides with you.

"**Domestic Student**" is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

(Definitions continued)

“Effective Date” means the first date a student becomes covered under the Policy.

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

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; and treatment of infertility.

“Experimental or Investigational Care” means a service or supply:

- (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
- (b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

“Hospital” means a facility which meets all of these tests:

- (a) it provides inpatient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it is run as a Hospital under the laws of the jurisdiction in which it is located.

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

“Hospital Confinement” means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

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

“Insured Person” means an Insured Student and his or her covered Dependent(s) while insured under this Policy.

“Insured Student” means a student of the Policyholder who is eligible and insured for coverage under this Policy.

“International Student” is a student classified as a Non-Immigrant. For example, students holding visa types: “F” (Student), “J” (Exchange Visitor), “B” (Tourist), or “A”

(Definitions continued)

(Diplomat).

“**Loss**” means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

“**Medical Emergency**” means the sudden and, at the time, unexpected onset of an Injury [or Sickness] that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but is not limited to:

- (a) placing the person’s health in significant jeopardy;
- (b) serious impairment to a bodily function;
- (c) serious dysfunction of any bodily organ or part;
- (d) inadequately controlled pain; or
- (e) with respect to a pregnant woman if she is having contractions:

- 1. that there is inadequate time to effect to safe transfer to another Hospital before delivery; or
- 2. that transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

“**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 Insured Person or provider;
- (b) it is not the appropriate treatment for the Insured Person’s diagnosis or symptoms;
- (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.

“**Network Providers**” are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

“**Non-Network Providers**” have not agreed to any pre-arranged fee schedules.

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

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

“**Usual, Reasonable and Customary Expenses**” means: a. Charges and fees for medical services or supplies that are the lesser of: The usual charge by the provider for the service or supply given; or The average charged for the service or supply in the area where service or supply is received; and Treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition.

“**We**”, “**Us**” and “**Our**” mean the Combined Insurance

(Definitions continued)

Company of America.

“**You**” and “**Your**” mean the Insured Person.

EXCLUSIONS

1. Services normally provided without charge by the Policyholder’s student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventive medicines, serums, immunizations, or vaccines, except as specifically provided;
3. Organ transplants, except as specifically provided;
4. Pre-existing Conditions as defined in this Policy.
5. Nonprescription drugs or medicines;
6. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
7. Injury resulting from motor vehicle accident to the extent that benefits are payable under any automobile medical expense insurance or automobile no-fault plans;
8. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
9. Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, racing or speed contests, skin diving, parachuting or bungi-cord jumping;
10. Correction of congenital defects except as specifically provided;
11. Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law;
12. Services incurred prior to the Insured Person’s Effective Date or during Hospital Confinement in one or more facilities which began prior to the Insured Person’s Effective Date;
13. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy;
14. Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain;
15. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
16. Medical services that are not Medically Necessary or that do not conform with medical standards of practice within the community. Also services and supplies in connection with Experimental or Investigational Care for the terminally ill;
17. Injury or Sickness resulting from declared or undeclared

(Exclusions continued)

- war; or any act thereof;
- 18. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
- 19. Injury due to participation in a riot;
- 20. Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;
- 21. For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters;
- 22. Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury, infection, or disease are not excluded;
- 23. Screening examinations, including X-ray examinations made without film, except as specifically provided;
- 24. Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, in-vitro fertilization, artificial insemination, and services or supplies for inducing conception;
- 25. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
- 26. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;
- 27. Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;
- 28. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury;
- 29. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
- 30. Expenses for any service or supply not specified in this Policy as a covered service;
- 31. An amount of a charge in excess of the Usual, Reasonable and Customary Expense;
- 32. Elective Treatment or elective surgery, except as specifically provided;
- 33. Services not Medically Necessary;
- 34. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
- 35. Treatment of mental or nervous disorders except as specifically provided;
- 36. Treatment of alcohol and substance abuse except as

(Exclusions continued)

- specifically provided;
- 37. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile;
- 38. Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;
- 39. Expense incurred for: tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism;
- 40. Voluntary or elective abortion;
- 41. Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drug, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery;
- 42. Expense incurred for: topical acne treatments, fertility medication; legend vitamins or food supplements; smoking deterrents; immunization agents; biological sera; drugs to promote or stimulate hair growth; experimental drugs; drugs dispensed in a rest home or hospital, except as provided under the Hospital Expense Benefit;
- 43. Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;
- 44. Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury;
- 45. Expenses incurred for services or supplies for the diagnosis and treatment of sleep disorders, including but not limited to apnea monitoring and sleep studies;
- 46. Services that have already been paid by another insurance carrier, even if those services would have otherwise been covered by this Plan;
- 47. Any treatment, service or supply in excess of the maximum benefit specified in this Policy;
- 48. Professional services billed by a Doctor or nurse who is an employee of a hospital or skilled nursing facility, and who is paid by that facility for the service.

FAIRMONT SPECIALTY TRAVEL ASSIST PLAN

Fairmont Specialty has provided a Travel Assistance Service through Europ Assistance USA (EA) which provides 24 hour services that can help you access emergency assistance when you are traveling 100 or more miles away from home. Europ Assistance USA is there when a crisis strikes to help you obtain the care and attention you need.

Over 850,000 multilingual service professionals stand ready to assist you in 200 countries and territories worldwide. These services are only eligible for payment or reimbursement if (EA) is contacted at the time of service and has arranged and/or pre-approved the service. Contact number: (877) 279-1913 (toll free Canada/US) and (240) 330-1433 (collect). www.europassistance-usa.com.

Services provided: Medical Evacuation up to \$50,000, Medical Repatriation up to \$50,000, Return of Dependent Children up to \$5,000, Return of Mortal Remains up to \$10,000, Return of Traveling Companion up to \$5,000. Other additional services including a Nurse Helpline are also available.

24-HOUR NURSE ADVICE LINE

Wouldn't you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. Europ Assistance USA (EA) 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 students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-877-279-1913 (toll free Canada/US) and (240) 330-1433 (collect).

DISCOUNT VISION PROGRAM

Because you are currently a member of Script Care's prescription drug program, you are also eligible to participate in the value-added Script Care Vision Program through EyeMed Vision Care. The discount vision program is available to all Script Care members at no additional cost and no premium.

How do members use the program?

Locate a participating eye care provider. When you arrive at your appointment, show your Script Care ID card and receive a discount on eye exams. There are no claims to file,

and there is no waiting for reimbursement.

How many providers participate in the program?

There are thousands of participating provider locations nationwide. Providers are conveniently located in stores like Lenscrafters, Sears, Target and most Pearle Vision Centers. For a list of providers near you, contact EyeMed Vision Care at 1-866-723-0391 or visit their website at www.eyemedvisioncare.com and reference Plan Code 9232869.

THIS IS NOT INSURANCE.

APPEALS PROCEDURE

Internal Appeal Procedure

If a claim is wholly or partially denied, a written notice or a message on the Explanation of Benefits (EOB) will be sent to the Covered Person containing the reason for the denial. The notice or message will include a reference to the provision in the Plan and a description of any additional information, which might be necessary for reconsideration of the claim.

If a Covered Person or the Covered Person's provider would like additional information or has any complaints concerning the basis upon which payment was made, they may contact our Claim Administrator, Summit America Insurance Services, LC at 877-246-6997. Administrator will address concerns and attempt to resolve them satisfactorily. If Administrator is unable to resolve a concern over the phone, it will request submission of the concern in writing to pursue a formal appeal.

A formal appeal must be submitted, in writing to Administrator at the following address:

Summit America Insurance Services, LC
7400 College Blvd., Suite 100
Overland Park, KS 66210

A formal appeal should include:

- The Covered Person's name, social security number, and home address;
- policy number; and
- any other information, documentation, or evidence to support the appeal.

A formal appeal must be submitted within 60 days of the event that resulted in the complaint. Administrator will acknowledge a formal appeal within 10 working days of its receipt or within 72 hours if the appeal involves a life-threatening situation. A decision will be sent to the Covered Person in writing within 30 days following receipt of the formal appeal. If there are extraordinary circumstances requiring a more extensive review and additional supporting documentation is required, the TPA may take up to an additional 60 days to review the formal appeal before rendering a decision.

Covered Person has the right to an External Appeal when health care services are denied by a health insurer on the basis that the services are not Medically Necessary or that the services are Experimental or Investigational.

(Appeals Procedure continued)

A “Final Adverse Determination” means written notification from the health plan that an otherwise covered health care service has been denied through the plan’s internal appeal procedures.

Eligibility for an External Appeal

To be eligible for an external appeal, an Covered Person or an Covered Person’s provider must have received a Final Adverse Determination as a result of the health plan’s internal review/appeal procedures OR the Covered Person and his/her health plan must have agreed to waive the internal appeal procedures.

If services are denied as Experimental or Investigational, the Covered Person must have a life-threatening or disabling condition or disease in order to be eligible for an external appeal AND his/her attending physician must complete and submit an Attending Physician Attestation form.

An external appeal may only be requested if the service or procedure that was denied is a covered benefit under the plan. The external appeal process cannot be used to expand Eligibility coverage under the plan.

For an Expedited External Appeal

If the attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to an Covered Person’s health, an expedited appeal may be requested. The request must include an Attending Physician Attestation form.

How to Request An External Appeal

An external appeal is requested by completing an application form, attaching a check for \$50.00 payable to United States Fire Insurance Company and sending it to the New York State Insurance Department within 45 days of receipt of a notice of Final Adverse Determination or within 45 days of receiving written confirmation from the health plan that the internal appeal procedure has been waived.

Time Frame for Decision

An expedited appeal will be decided by an external appeal agent within three days of receiving a request for an external review from the state.

An external appeal agent will decide a standard appeal within 30 days of receiving the request from the state.

If the external appeal agent overturns the denial, a Covered Person’s fee will be refunded.

Insured Persons, his/her designated representative, or a provider may contact the Director of the Missouri Department of Insurance for assistance at any time at 1-800-726-7390 or write to Missouri Department of Insurance, P.O. Box 690, 301 West High Street, Truman Building, Room 630, Jefferson City, Missouri 65102-0690.

CLAIM PROCEDURE

In the event of Injury or Sickness students should:

1. Report to a Physician or Hospital.
2. Mail all medical and hospital bills along with the patient's name and insured student's name, address, social security number and name of the university under which the student is insured. A company claim form is not required for filing a claim. A written notice of claim must be submitted to the address below within 90 days after expenses incurred, or as soon thereafter as reasonably possible. Upon receipt of a notice of claim, the Company will furnish the Insured the necessary forms for filing proof of loss. If the person making claim does not receive the necessary claim forms before the expiration of 15 days after first requesting such forms, the Insured shall be deemed to have complied with the requirements as to the proof of loss upon submitting to the Company within 90 days written proof covering the occurrence, character and extent of the loss for which claim is made.
3. File claim within 90 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service.
4. The Insured's failure to give notice within such time will not invalidate nor reduce any claim if it is shown that notice was given as soon as was reasonably possible. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Submit all Claims or Inquiries To:

Summit America Insurance Services, LC

7400 College Blvd., Suite 100

Overland Park, KS 66210

1-877-246-6997

or email claims related questions to:

claims@summitamerica-ins.com

Submit all Claims, Claims Inquiries, Premium and Eligibility Questions To:

Summit America Insurance Services, LC

7400 College Blvd., Suite 100

Overland Park, KS 66210

www.summitamerica-ins.com

Call Toll Free 1-877-246-6997

or email claims related questions to:

claims@summitamerica-ins.com

Hours of Operation: Monday - Friday 8:30 a.m. to
5p.m. Central Standard Time

Preferred Provider Information:

First Health Network

1-888-685-7774

www.firsthealth.com

Pharmacy Network Information:

Script Care, LTD

1-800-880-9988

www.scriptcare.com

Sales/Marketing Services:

Summit America Insurance Services, LC

7400 College Blvd., Ste. 100

Overland Park, KS 66210

1-800-955-1991

Hours of Operation: Monday - Friday 8:30a.m. to
5p.m. Central Standard Time

www.summitamerica-ins.com

Please visit the Student Development website at www.rockhurst.edu to view and print Brochures, Enrollment Forms, ID Cards and Frequently Asked Questions.

Please keep this brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.