CREATING THE
LEADERS OF TOMORROW

REQUEST FOR PROPOSAL
RFP # 24-01R

STUDENT ACCIDENT INSURANCE

PROPOSAL TO BE RECEIVED ON OR BEFORE

May 4, 2023

11:00 AM

SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT
60 WESTON STREET
HUNTINGTON STATION, NY 11746
Telephone (631) 812-3015
Fax (631) 812-3019

DATE: March 13, 2023

REQUEST FOR PROPOSAL

INVITATION

Sealed Proposals, for furnishing the services specified below, subject to terms and conditions stated herein will be received at the office of the Purchasing Department and publicly opened there at 11:00A.M. on: **May 4, 2023**

TO:

Return to:

Commitment to Excellence

SOUTH HUNTINGTON
UNION FREE SCHOOL DISTRICT
60 WESTON STREET
HUNTINGTON STATION, NEW YORK 11746

(631) 812-3015 - FAX: (631) 812-3019

VERY IMPORTANT

1. The proposer in signing the proposal certifies that to the best of their knowledge and belief the prices quoted are not in excess of the legal maximum prices established by government controls.
2. The delivery date indicated is as required by the School District. If you cannot meet it, cross it out and insert your own best delivery time.
3. ALL PROPOSALS MUST BE SIGNED IN INK

THIS IS NOT AN ORDER

PROPOSER'S ACCEPTANCE

_____
(FIRM NAME)

_____
(PLEASE PRINT NAME AND TITLE)

_____
(AUTHORIZED SIGNATURE)

_____ _____
(DATE) (PHONE NUMBER)

FAX NO._____

This is a Request for Proposal for **STUDENT ACCIDENT INSURANCE** in accordance with the enclosed materials.

If you have any questions regarding this bid, please contact Mrs. Sheila Buhse at 631-812-3015.

REQUEST FOR PROPOSAL
STUDENT ACCIDENT INSURANCE
#24-01R

DATE OF OPENING: May 4, 2023 **TIME: 11:00 A.M.**

The South Huntington UFSD, hereinafter referred to as "the District", invites proposals from qualified insurance firms to provide student accident insurance. Information provided in these specifications is to be used only for the purposes of preparing a proposal detailing costs of providing the insurance coverage specified.

1. PURPOSE:

The District is seeking proposals from qualified insurance firms to provide student accident insurance. Offerors are requested to submit quotations on the basis of these specifications. Alternative quotation will receive consideration provided such alternatives are clearly explained. Any exceptions to coverage requested herein must be clearly noted in writing and be included as part of the proposal. The District prefers to have coverage consolidated in as few policies as possible but this consideration will be subordinate to cost and coverage quality considerations.

To assist offerors with proving their proposal the following items are included:

- Copy of District Insurance Policy (Appendix A)
- Insurance Information Sheet (Appendix B)
- Premium Summary Sheet (Appendix C)

2. GENERAL INFORMATION:

Any inquiries concerning the request for proposals should be addressed to Sheila Buhse, School Purchasing Agent, via mail to the address listed below, or via e-mail at sbuhse@shufsd.org.

3. PROPOSAL SUBMISSION:

Proposals must be submitted in sealed opaque envelopes clearly marked **Student Accident Insurance** and the name and address of the proposer. Proposals must be received no later than **11:00 AM on May 4, 2023** at the following address:

Purchasing Department
South Huntington UFSD
60 Weston St
Huntington Station NY 11746
ATTENTION: SHEILA BUHSE

There is no expressed or implied obligation for the District to reimburse responding individuals for any expenses incurred in preparing this quotation, attending a pre-quotation conference, or interview(s) in responding to this request. Proposals submitted after the stated time and date will not be considered and will be returned to the individual unopened.

4. **CONTRACT TERM:**

The contract shall be in effect for the period of July 1, 2023 thru June 30, 2024 with an option to renew for four (4) additional one-year periods, at the discretion of the District, not to exceed the prices indicated in the firm's proposal submission.

5. **SUBMISSIONS:**

All proposals must contain the following information and must contain complete cost and pricing information. Two copies of each proposal must be submitted. One copy should be marked, "ORIGINAL" and the second should be marked, "COPY," and should be submitted in a format that permits multiple copying for review by the district.

Each page of the proposal must state:

- Name of the Firm or Individual submitting the proposal.
- Proposal is for South Huntington School District's **Student Accident Insurance**
- Page number

All proposals must be submitted in two parts:

- Part I must consist of responses to the management and qualification items.
- Part II must consist of completed Cost Proposal sheets(s).

Incomplete submissions will not be considered for award. Proposals should not be excessively long and should be submitted in a format that permits copying for review. All materials submitted in response to this request for proposal shall become the property of the District.

6. **RESERVATION OF RIGHTS**:

The District reserves the right, without prejudice, to reject any or all proposals not in compliance with the Request for Proposal specifications, as well as to ignore material defects if, in its sole discretion, the District determines that doing so is in its best interest.

The District reserves the right to negotiate the terms of the contract, including the award amount, with the selected vendor prior to entering a contract.

Submission of a proposal indicates acceptance by the firm of the conditions contained in this Request for Proposal, unless clearly and specifically noted in the proposal submitted and confirmed in the contract between the District and the firm selected.

7. **PROPOSAL REQUIREMENTS**:

The proposal must be submitted in two parts. Part I must consist of response to the management and qualifications items. Part II must consist of complete contract cost and pricing information. Incomplete submissions may not be considered for award. Proposal should not be excessively long, and should be submitted in a format that permits copying for review. Unnecessary attachments beyond those sufficient to present a complete, comprehensive, and effective response will not influence the evaluation of the proposal. The District reserves the right to request additional data or material at any time. All material submitted in response to the Request for Proposal will become the property of the District.

8. REFERENCES:

The firm must include its three (3) references that you have used over the course of the past five (5) years with similar scope of work, including agency name, contact person, address and telephone number. The District may contact the clients to determine the quality of work performed and personnel assigned to those projects.

9. FINAL SELECTION:

- Board of Education will approve a firm based upon the recommendation of the Superintendent and the Deputy Superintendent for Business and District Operations.
- It is anticipated that a firm will be selected by June 14, 2023. Following notification of the firm selected, it is expected a contract will be executed between both parties by June 20, 2023 for service to begin July 1, 2023.
- Right to reject proposals.

10. SCOPE OF SERVICES:

Provide insurance coverage as specified on Appendix B, Insurance Information Sheet.

PART I
MANAGEMENT AND QUALIFICATIONS

In setting forth your qualifications, each individual submitting a proposal shall:

A. Although offers will be accepted for carriers regardless of the **Best's** rating (or regardless of whether or not they are rated by **Best's**), more favorable consideration will be given to those proposals submitted by carriers with ratings of at least A:XI in the most recent **Best's Property and Liability Report**;

B. Insurers shall be duly licensed and comply with all applicable New York State insurance laws and requirements;

C. Describe the firms experience and expertise in student accident insurance including the number of years your firm has provided such insurance, including to school districts;

D. State the names and titles of the Account Coordinator;

E. Provide summary information regarding the professional experience and qualifications of supervising and support personnel who shall perform work under the contract;

F. Identify the nature of any potential conflict of interest the firm might have in providing this or any other work for the District;

G. Provide any other information you believe would be beneficial to the District and indicators that the firm understands the work to be performed.

PUPIL BENEFITS PLAN, INC.

(A Non-Profit Corporation)
101 DUTCH MEADOWS LANE, GLENVILLE, NY 12302
(Hereinafter called "The Plan")

THE PLAN DOES HEREBY CERTIFY that each of the students attending:

SOUTH HUNTINGTON

is entitled to medical, hospital and dental services indemnity in accordance with its terms and conditions, when accidental bodily injury is sustained by the insured student while engaging in a School Sponsored Activity specified herein, which activity is under the sole jurisdiction of the Board of Education and is supervised by personnel employed by the Board of Education and in accordance with the Regulations of the Commissioner of Education as well as the Rules and the Game Standards of the New York State Public High School Athletic Association. The coverage provided by this contract is for the school year [2022- 2023].

PERIOD OF CONTRACT

Coverage commences on July 1st and remains in force until June 30th.

NON-DUPLICATION PROVISION

No benefits will be paid to the extent that benefits are payable therefore under any other policy or prepayment plan, including a plan under Federal or other government law except Medicaid, and the premium is paid in full by the school district.

This contract is renewable at the option of the Plan at the premium rates in force at the time of renewal. If the Plan chooses not to renew this contract, at least 30 days prior notice of such non-renewal will be provided. The premium is subject to your experience rating based on excessive claim loss and subject to additional premium. The Experience Rating Plan has been filed with the New York State Department of Financial Services.

The Plan will issue to the school, for delivery to each Member, a certificate setting forth the essential features of the insurance protection to which the Insured Member is entitled and to whom benefits hereunder are payable.

COVERAGE	RATE PER PUPIL PER SCHOOL YEAR
R	$ 12.52

IN WITNESS WHEREOF Pupil Benefits Plan, Inc., has caused this contract to be issued by its duly authorized officer at 101 Dutch Meadows Lane, Glenville, New York 12302, this

1ST day of **JULY**, **2022**

DISTRICT ID:

SHUNT

Thomas McGuire

Executive Director

COVERED EXPENSES

Payment shall be made based on the usual and customary charges for:

- Medical and surgical care by a licensed physician;
- Care and services provided at a hospital that are medical in nature;
- Ground Ambulance service from the site of incident;
- Dental care of sound and natural teeth;

Replacement or repairs of previous restorations will be limited to 50% of the scheduled indemnity. Restoration associated with dental claims classified by the plan as "open dental" must be completed within 90 days after the insure is graduated or left high school. Removable dentures should be removed prior to any participation.

- Orthopedic appliances prescribed by the treating physician;
- Drugs and medicine prescribed by the treating physician;
- Restorative Physiotherapy when provided by a licensed physical therapist;
- Services provided by a chiropractor.

Expenses incurred for care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof where such interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column will be eligible for reimbursement.

AGGREGATE MAXIMUM OF $50,000.00; MAXIMUM AGGREGATE DENTAL BENEFITS WILL BE LIMITED TO $1000.00 WHEN TREATMENT EXTENDS OVER 12 MONTHS FROM THE DATE OF INJURY.

DEDUCTIBLE: NONE

EXCLUSIONS: NO BENEFITS SHALL BE PROVIDED FOR:

- Cosmetic surgery (cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma), sickness, disease, or orthodontia treatment.
- Intentionally self inflicted injuries.
- Injuries sustained during participation in a felony, riot, or insurrection.

LIMITATIONS:

- For sports injuries, the physicians written date of discharge and permission to re-participate terminates benefits for that injury and re-activates insurance coverage for subsequent sports injuries, providing that no benefits will be paid for treatment incurred for that first injury more than one (1) month after permission to participate.
- No benefits will be paid unless the first treatment has been provided within 90 days from the date of injury.
- No benefits will be paid for treatment after 3 years have elapsed from the date of injury (except Open Dental).

GENERAL PROVISIONS

- The amount allowed will not exceed the physicians or dentists itemized statement which must accompany every request for benefit.
- A grace period of forty-five days will be allowed for making any premium payment due under this policy. After a default in the payment of any premium under this policy, the subsequent acceptance of a payment by the Corporation or by one of its duly authorized agents shall reinstate the policy, but only to cover injuries occurring after the date of such acceptance.
- No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of this policy and no such action shall be brought at all unless brought within three years from the expiration of the time within which proof of loss is required by the policy.

ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY:

If a covered injury results in any of the losses specified below within 100 days after the date of the accident, the Plan will pay:

For loss of:

Life.....$5,000.00 (Principal Sum)
Two or more members.....$10,000.00 (Double Dismemberment Indemnity)
One member.....$5,000.00 (Single Dismemberment Indemnity)

"Member" means hand, foot or eye. Loss of hand or foot means complete severance above the wrist or ankle joint. Loss of eye means the total, permanent loss of sight. These benefits are payable in addition to any covered medical expense benefits paid as a result of the accident.

If the Principal Sum is payable, no indemnity will be paid for dismemberment. In any event, the Double Dismemberment Indemnity is the maximum amount payable under this benefit for all losses resulting from one accident.

Pupil Benefits Plan, Inc. does not have realtionships with any third party, affiliated or non-affiliated, where nonpublic financial or health information could be exchanged. Our privacy policy applies to all products and services. All information will be protected as required by law.

GERBER LIFE INSURANCE COMPANY

1311 Mamaroneck Avenue
White Plains, NY 10605

BLANKET ACCIDENT INSURANCE POLICY

POLICYHOLDER:	South Huntington UFSD 60 Weston St Huntington Station, NY 11746
POLICY NUMBER:	32-060906-22
POLICY EFFECTIVE DATE:	July 1, 2022
POLICY ANNIVERSARY	July 1
POLICY TERM:	July 1, 2022 through June 30, 2023
STATE OF ISSUE:	New York

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date shown above at the Policyholder's address. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. This Policy terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Policyholder and We agreed to continue coverage under this Policy for an additional Policy Term. The laws of the State of Issue govern this Policy.

We and the Policyholder agree to all the terms of this Policy.

SIGNED FOR GERBER LIFE INSURANCE COMPANY

Keith M. O'Reilly
President and CEO

Ayana Gordon
Secretary

THIS IS A LIMITED POLICY WHICH PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENTS ONLY IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS

THIS IS ACCIDENT-ONLY INSURANCE. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MINIMUM ESSENTIAL COVERAGE (MEC) MAY RESULT IN ADDITIONAL PAYMENT WITH COVERED PERSONS' TAXES.

PLEASE READ THIS POLICY CAREFULLY
NON-PARTICIPATING

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the section describing the *Hazards Insured Against* and each Benefit Description section for full details.

Eligible Persons: An Eligible Person is an individual who meets all of the requirements of one of the Covered Classes shown below:

Class 1 — Grades PreK-K, Grades 1-8, Grades 9-12, Interscholastic Sports & Football participants, Overnight Field Trip participants.

HAZARDS INSURED AGAINST

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, if a Covered Person sustains a Covered Injury or suffers a Covered Loss while coverage is in force to protect against the following hazards:

School Activities Hazard

Personal Deviations covered	No
Personal Deviation takes place	N/A
Maximum Length of Personal Deviation	N/A

Covered Activity — On School premises during the hours and days when school is in session; participating in interscholastic sports; acting as a student coach, student manager or student trainer during an interscholastic sports practice or game; participating in cheerleading practice for an interscholastic sport or while cheerleading at an interscholastic game; participating in band or majorette practice and while performing as a band member or majorette at a school sponsored event; participating in school sponsored intramural sports games; participating in a school sponsored gym class activity; and participating in a school sponsored non-sport extracurricular activity on or off school premises, such as but not limited to drama club, chess club and field trips of fewer than eight consecutive nights. Trips of longer duration are considered Supervised and Sponsored School Activities only if We have agreed in writing to insure them.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum	$10,000
Single Dismemberment Maximum	$ 5,000
Double Dismemberment Maximum	$10,000
Loss other than Death must occur within	365 days of the Covered Accident
Loss of Life must occur within	365 days of a Covered Accident

SCHEDULE OF COVERED LOSSES

Covered Loss	**Benefit**
Loss of Life	$10,000
Loss of Both Hands or Both Feet	$10,000
Loss of Sight of Both Eyes	$10,000
Loss of One Hand and One Foot	$10,000
Loss of One Hand and Sight of One Eye	$10,000
Loss of One Foot and Sight of One Eye	$10,000
Loss of One Hand or Foot	$ 5,000
Loss of Sight in One Eye	$ 5,000
Loss of Speech and Hearing (in both ears)	$10,000
Loss of Speech	$10,000
Loss of Hearing in both ears	$10,000
Loss of Thumb and Index Finger of the Same Hand	$10,000

ACCIDENT MEDICAL BENEFITS

Any benefit limits and benefit percentages for *Accident Medical Benefits* apply, unless otherwise specified, on a per Covered Person – per Covered Accident basis. Any applicable Deductibles must be satisfied within the time periods specified before benefits are payable.

SCOPE OF COVERAGE APPLICABLE TO ACCIDENT MEDICAL BENEFITS

Full Excess Medical Expense

ACCIDENT MEDICAL EXPENSE BENEFIT

Total Maximum for all Accident Medical Expense Benefits	$5,000,000
First Covered Expenses must be Incurred within	180 days after the Covered Accident
Benefit Period	10 years from the date of the Covered Accident
Deductible applies to	$50,000 each Covered Accident

The Covered Person may use Covered Expenses paid under another Health Care Plan to satisfy the Deductible under this Policy.

Deductible must be Satisfied within 730 days from the date of the Covered Accident

Covered Expenses for which benefits are payable are outlined below. Unless otherwise indicated, benefits are payable as a percentage of Usual and Customary Charges.

Covered Expenses	Benefit Percentage and Other Limits
In-Patient Hospital Services	
Room and Board Expenses	
Intensive Care Unit or Coronary Care Unit	100% up to the daily intensive care unit room rate
Private/Semi-Private Room	100% up to the semi-private daily room rate
Hospital Miscellaneous Expenses	100%
Ambulatory Medical or Surgical Center	100%
Emergency Room Treatment	100%
Emergency Room Physician	100%
Out-Patient Hospital Miscellaneous Expenses	100%
Physician Services	
Surgery	100%
Assistant Surgeon	100%
Anesthesia and its Administration	100%
In-Hospital Visits	100%
Office Visits	100%
Out-Patient X-Rays	100%
Out-Patient CT Scans & MRIs	100%
Out-Patient Laboratory Tests	100%
Out-Patient Physical Therapy	100% up to $100,000
Occupational and Speech Therapy	100% up to $100,000

Covered Expenses	Benefit Percentage and Other Limits
Nursing Services	100%
Ambulance Services	
Ground Ambulance Maximum	100%
Air Ambulance Maximum	100%
Medical Equipment Rental	100% up to $25,000
Prosthetic Devices	
Benefit Amount	
Prosthetic Leg	
-If amputation is below the knee	100% up to $200,000
-If amputation is above the knee	100% up to $300,000
Dental Services	100%
Prescription Drugs	100%
Home Health Care	100% up to $500 per day
Minimum Hospital Stay	10 consecutive days
Home Health Care must begin within	10 consecutive days after the Minimum Hospital Stay
Maximum Number of Home Health Care Visits	200 per calendar year or consecutive 12-month period
Extended Care Facility	100% up to $1,000 per day
Minimum Hospital Stay	10 consecutive days
Extended Care must begin within	10 consecutive days after the Minimum Hospital Stay

PREMIUM RATE TABLE

It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

Covered Activities and Rates

Grades PreK-K (per student)	$0.47
Grades 1-8 (per student)	$0.67
Grades 9-12 (per student)	$1.77
Overnight Field Trips (per participant)	No Charge
Total Premium Due:	$6,074.03
Mode of Premium Payment	Single Premium
Premium Due Date	Policy Effective Date

Contributions The cost of the coverage is paid by the Policyholder.

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below. They are capitalized wherever they appear in this Policy.

Aircraft means a vehicle which:

1. has a valid Certificate of Airworthiness; and
2. is being flown by a properly qualified pilot with a valid license to operate the Aircraft.

Ambulatory Medical or Surgical Center means any licensed public or private establishment which:

1. has an organized medical staff;
2. has permanent facilities that are equipped and operated mainly for the purpose of providing medical or surgical treatment;
3. provides continuous services of Physicians and registered nurses, whenever a patient is in the facility; and
4. does not provide services or other accommodations for patients to stay overnight.

Appropriate Treatment means care, services or supplies provided to a Covered Person, solely by or at the direction of a treating Physician exercising prudent medical judgment and acting independently of the Company, for the purpose of evaluating, diagnosing or treating a Covered Injury sustained as the direct result of a Covered Accident, that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration;
3. considered effective for the Covered Injury;
4. not primarily for the convenience of the Covered Person, the Covered Person's Physician or any other Physician; and
5. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of a Covered Injury.

   For the purposes of this definition, Generally Accepted Standards of Medical Practice means:

   a. standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
   b. Physician and health care provider specialty society documents;
   c. The views of Physicians and health care providers practicing in the relevant clinical areas; and
   d. any other relevant factors.

Benefit Percentage means the percentage of Covered Expenses We pay that are Incurred by the Covered Person after he satisfies any applicable Deductible. Benefit Percentages are shown in the *Schedule of Benefits*.

Benefit Period means a period, shown in the *Schedule of Benefits* and commencing with the date of the first Covered Expense Incurred for treatment of a Covered Injury sustained as the direct result of a Covered Accident, during which Benefits are payable.

Certificate of Airworthiness means the standard airworthiness certificate issued by the Federal Aviation Administration of the United States or its foreign equivalent.

Common Carrier or Public Conveyance means:

1. a Conveyance, including an Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command of the United States of America or similar air transport service of another country.

Company or **We, Us, Our** means Gerber Life Insurance Company, domiciled in White Plains, New York.

Conveyance means a motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority.

Covered Accident means a sudden, unforeseeable event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2 occurs while coverage is provided to protect against one of the hazards specified in the *Schedule of Benefits;*
3. is not contributed to by disease, Sickness, or mental or bodily infirmity;
4. is not otherwise excluded under the terms of this Policy.

Covered Activity means any recurring activity or event that is shown in the *Schedule of Benefits* and:

1. takes place while coverage is provided to protect against one of the hazards specified in the *Schedule of Benefits;* and
2. is sponsored, organized, scheduled or otherwise provided by the Policyholder.

The activity must be under sole direct supervision of qualified Policyholder authorities and may, if specified in the Policy, include Policyholder sponsored and supervised travel to and from such an activity.

Covered Expenses means the Usual and Customary charges for services or supplies listed in the *Schedule of Benefits,* and described in the *Accident Medical Benefits* section, that the Covered Person Incurs during the Benefit Period for Appropriate Treatment of a Covered Injury. A Physician must recommend and approve these services or supplies.

Covered Injury means any bodily harm that results, directly and independently of all other causes, from a Covered Accident. A Covered Injury does not include aggravation of an injury sustained before the Covered Accident.

Covered Person means an Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due, and for whom coverage under this Policy remains in force.

Covered Loss means a loss:

1. which is the result of a Covered Injury to a Covered Person;
2. for which benefits are payable under this Policy; and
3. which is not otherwise excluded under the terms of this Policy.

Daily Living Services means cooking, feeding, bathing, dressing and personal hygiene services performed by a Home Health Aide which are necessary to the care and health of the Covered Person.

Deductible means the amount of Covered Expenses that each Covered Person must Incur, as applicable, before benefits are paid under this Policy. The Deductible may apply to each Covered Accident or each Policy Term, as shown in the *Schedule of Benefits*.

Extended Care Facility means an institution operating pursuant to applicable law and engaged in providing, for a fee, in-patient skilled nursing care and related services and physical therapy services under the supervision of a Physician and registered Nurses. An Extended Care Facility must maintain medical records on all of its patients.

Treatment rendered in an Extended Care Facility does not include routine custodial care.

He, His, Him refers to any individual, male or female.

Health Care Plan means any arrangement, whether individually purchased or incident to employment or membership in an association or other group, which provides benefits or services for health care, dental care or disability benefits. A Health Care Plan includes group, blanket, franchise, family or individual:

1. insurance policies;
2. subscriber contracts;
3. uninsured or self-funded agreements or arrangements;
4. coverage provided through Health Maintenance Organizations, Preferred Provider Organizations and other prepayment, group practice an individual practice plans;
5. medical benefits provided under automobile "fault" and "no-fault"–type contracts;
6. medical benefits provided by any governmental plan or coverage or other benefit law, except:
   a. a state-sponsored Medicaid plan; or
   b. a plan or law providing benefits only in excess of any private or non-governmental plan;
7. other valid and collectible medical or health care benefits or services.

Home means the structure or land in or on which the Covered Person permanently resides.

Home Health Care Agency means an agency that:

1. is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. is engaged primarily in providing Extended Care Facility services and other therapeutic services in the Covered Person's Home under the supervision of a Physician or a Nurse; and
3. maintains clinical records on all patients.

Home Health Aide is a person who:
1. provides care of a medical or therapeutic nature, or who provides Daily Living Services; and
2. reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care means the care and treatment of a Covered Person who is under the care of a Physician but only if hospitalization or confinement in a nursing facility as defined in subchapter XVIII of the Federal Social Security Act, 42 U.S.C. §§ 1395 et seq, would have otherwise been required if home health care was not provided, and the plan covering the home health service is established and approved in writing by the Covered Person's Physician

Hospital means a short-term acute care general hospital which:
1. is primarily engaged in providing to inpatients, by or under the continuous supervision of physicians, diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons; and
2. has organized departments of medicine and major surgery; and
3. has a requirement that every patient must be under the care of a physician or dentist; and
4. provides 24-hour nursing services by or under the supervision of a graduate registered professional nurse (R.N.); and
5. 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 the United States Public Law 89-97 (42 USCA 1395(k)(0); and
6. is duly licensed by the agency responsible for licensing such hospitals; and
7. 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 retaliatory care.

Hospital Stay means a confinement in a Hospital, ordered by a Physician, over one or more nights when room and board and general nursing care are provided at a per diem charge made by the Hospital. The Hospital Stay must result directly and independently of all other causes from a Covered Accident. Separate Hospital Stays due to the same Covered Accident will be treated as one Hospital Stay unless separated by at least 90 days.

Immediate Family Member means a person who is related to the Covered Person in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent, including stepparent, brother or sister, including stepbrother or stepsister, or child, including legally adopted child or stepchild.

Incurred or Incurs means an obligation to pay for a Covered Expense for treatment, service or purchase of supplies, deemed to be the date it is provided to the Covered Person.

In-Patient means a Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse means a licensed graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:
1. the Covered Person;
2. an Immediate Family Member of either the Covered Person or the Covered Person's spouse; or
3. a person employed or retained by the Policyholder.

Out-Patient means a Covered Person who receives Appropriate Treatment, services and supplies while not an Inpatient in a Hospital.

Physical Therapy means any form of physical therapy, whether by machine or hand, by use of exercise, manipulation, massage, adjustment, heat or cold, air, light, water, electricity or sound.

Personal Deviation means an activity which:
1. is not reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and
2. the Covered Person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in the section of the *Schedule of Benefits* that lists the Hazards Insured Against.

Physician means a legally qualified practitioner of the healing arts acting within the scope of his license and rendering care and treatment for the Covered Person that is appropriate for the condition and locality, and who is not
1. the Covered Person; or
2. An Immediate Family Member of the Covered Person or his spouse.

Private Passenger Automobile means a validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other Public Conveyance will not be considered a Private Passenger Automobile.

Rehabilitation Facility means a legally operating institution or part of an institution which has a transfer agreement with one or more Hospitals and which:

1. is primarily engaged in providing comprehensive multi-disciplinary physical rehabilitative services or rehabilitation inpatient care; and
2. is duly licensed by the appropriate government agency to provide such services; and
3. is required to be accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities.

A Rehabilitation Facility does not include institutions which provide only minimal care, custodial care, care for the terminally ill, part-time care, or services or facilities for drug abuse or alcoholism.

School means the School where the Covered Person is enrolled or employed. The School must be licensed or accredited, as applicable, by the jurisdiction where it is located, to provide the care, education or training for which the Covered Person is enrolled.

Sickness means a physical or mental illness, including pregnancy.

Surgical Procedure means:

1. a cutting procedure;
2. suturing a wound;
3. treatment of a fracture;
4. reduction of a dislocation;
5. electrocauterization;
6. diagnostic and therapeutic endoscopic procedures; and
7. an operation by means of laser beam.

Usual and Customary Charge means the normal charge, in the absence of insurance, made by the provider of any Appropriate Treatment, but not more than the prevailing charge in the area:
1. for a like service by a provider with similar training or experience; or
2. for a supply that is identical or substantially equivalent.

War means a state or period of declared or undeclared war whether civil or international, any substantial armed conflict with organized forces of a military nature between nations, states or parties.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Policy Effective Date
We agree to provide Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Eligibility
A person is eligible for insurance under this Policy when he meets the definition of an Eligible Person shown in the *Schedule of Benefits.* An Eligible Person may be insured under only one Covered Class, even though he may be eligible under more than one Covered Class.

Effective Date for Individuals
Insurance becomes effective for the Eligible Person on the latest of the following dates:
1. the Policy Effective Date;
2. the date the person becomes eligible;
3. the effective date of this Policy.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Covered Person's Covered Class

Will take effect on the date of such change.

Termination of Insurance
Insurance for the Covered Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class; and
2. the date the person enters full time active duty in any Armed Forces. We will refund any premium paid for any period of active duty when We receive proof of active duty. Active duty does not include Reserve or National Guard duty for training; and
3. the end of the period for which the last premium is made; and
4. the date this Policy ends

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earlier of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit, as shown in the *Schedule of Benefits*, have been paid.

GENERAL EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury, Covered Loss or Covered Expense which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in this Policy:

1. suicide, attempted suicide or intentionally self-inflicted Injury;
2. participation in a felony;
3. participation in a riot or insurrection;
4. war or act of war, whether declared or undeclared;
5. service in the Armed Forces or units auxiliary thereto;
6. air travel, except as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
7. treatment of a Covered Accident first manifesting itself while the Covered Person is outside the United States, its possessions or the countries of Canada and Mexico;
8. services performed by a member of the Covered Person's immediate family; or
9. injuries for which benefits are provided under any State or Federal workers' compensation, employer liability or occupational disease law.

CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice must be given to Us or Our agent within 31 days after a Covered Accident occurs or the loss begins, or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given at Our Home Office in White Plains, New York, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Policyholder's name and policy number and the Covered Person's name and address.

Claim Forms
We send forms for filing proof of loss when We receive the notice of claim. If claim forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 120 days of the loss for which claim is made. If: (a) benefits are payable as periodic payments; and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 120 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible.

Time of Payment of Claims
We will pay benefits due under this Policy for any loss, other than a loss for which this Policy provides any periodic payment, immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefit descriptions. Any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us, unless otherwise stated in this Policy.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate. If any payee of benefits is a minor or otherwise legally incompetent, we will pay benefits to the person designated as his legal guardian or conservator.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability for that payment.

Beneficiary
The beneficiary is the person or persons the Covered Person names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Covered Person has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to him, We may make direct payment to the estate of the Covered Person or to the first surviving class of the following classes of persons:

1. Spouse;
2. Child or Children;
3. parents;
4. siblings.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought more than two years after the time such written proof of loss must be furnished.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

ADMINISTRATIVE PROVISIONS

Cancellation
We or the Policyholder may cancel this Policy, after the first year Policy Term, by giving the other party 31 days advance written or authorized electronic notice. Any premium rate guarantee will not affect Our or the Policyholder's right to cancel this Policy.

If We cancel this Policy, any earned premium will be computed pro rata and any unearned portion promptly returned to the Policyholder. If the Policyholder cancels this Policy, any unearned premium paid to Us will be returned to the Policyholder immediately; or the Policyholder will immediately pay any earned premium to Us that has not been paid. Earned premium will be computed pro rata.

If a premium is not paid when due, We will cancel this Policy at the end of the last period for which premium was paid, subject to the Grace Period provision. Premium Due Dates are shown in the *Schedule of Benefits*.

Cancellation does not affect a claim for a Covered Loss when the Covered Accident occurs before the cancellation date.

Premiums
Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Premium Rate Table*, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. If Covered Persons' coverage amounts are reduced due to age, premium will be based on the amounts of coverage in force on the day before the reduction took place. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder.

Premium Payment
The total premium paid by the Policyholder is the sum of premiums for all Covered Persons. The initial premium is due on the Policy Effective Date unless the Policyholder and We agree to another mode of premium payment. Premiums are paid at Our Home Office or to Our authorized agent.

If any premium is not paid when due, this Policy will be cancelled as of the Premium Due Date of the unpaid premium, except as provided in any applicable Policy Grace Period section.

Premium Rate Changes
We may change premium rates at the end of any Policy Term with at least 31 days advance notice mailed to the last known address of the Policyholder. We will not increase premium rates more frequently than annually, unless one of the events described below occurs.

We may change the premium rate during a Policy Term if any one of the following occurs:

1. the terms of this Policy change;
2. the number of Covered Persons increases or decreases by more than 10% since the later of the Policy Effective Date and the date of the last renewal of this Policy;
3 an acquisition, merger, consolidation, divestiture, corporate reorganization or purchase or sale of assets affecting, increasing or decreasing by 10% or more the number of Covered Persons;
4. a change in any federal or state law or regulation is enacted, adopted or amended to the extent it affects Our benefit obligations under this Policy;
5. the Policyholder fails to provide sufficient information, as required by Us, to confirm adequacy of premiums and rates currently being paid; or
6. any reinsurance obtained by Us in connection with underwriting or renewal of the Policy is terminated for any reason, or if its cost increases by 10% or more, or Our retention increases by 10% or more.

Any increase or decrease in rate will take effect on the date of the applicable change specified above, subject to required notification. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

Premium Audit
We will have the right to audit books and records of the Policyholder at its place of business and during its regularly-scheduled business hours, in order to determine the accuracy of premiums paid.

Refund of Premium
We will refund any premium paid for coverage of a specified Covered Activity if:

1. that Covered Activity is cancelled; and
2. the Policyholder notifies Us in writing at least 14 days before the Covered Activity was scheduled to take place.

No insurance will be in effect for any Covered Person while he participates in, travels to, attends or otherwise is involved in the cancelled Covered Activity. If this Policy was issued to insure only the Covered Activity that was cancelled and We were notified as required in 2. above, this Policy will be void from its inception.

GENERAL PROVISIONS

Entire Contract; Changes
This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached, as an amendment signed by the Policyholder and us, to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

If an enrollment form of any Covered Person is required, it may also be made a part of this Policy at Our option.

Misstatement of Fact
If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Assignment
The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.

This insurance may not be levied on, attached, garnished, or otherwise taken for a person's debts unless contrary to law.

Incontestability
Of This Policy
All statements made by the Policyholder to obtain this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy unless a signed copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

Certificates
We will provide a certificate of insurance for delivery to each Covered Person. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

Reporting Requirements
The Policyholder or its authorized agent must report all of the following to Us by the premium due date:

1. the names of all persons insured on the Policy Effective Date;
2. the names of all persons who are insured after the Policy Effective Date;
3. the names of those persons whose insurance has terminated;
4. additional information required by Us.

Clerical Error
A person's coverage validly in force will not be affected, nor will a person's coverage validly terminated be continued, due to error or delay in keeping records pertaining to insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Records
The Policyholder or its authorized administrator will maintain the records of the Covered Person's insurance under this Policy. We will be permitted to examine the Policyholder's records relating to the insurance under this Policy at any reasonable time. The Policyholder is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Policyholder will not be considered Our actions.

Examination of the Policy
This Policy will be available for inspection at the Policyholder's office during regular business hours.

Conformity with Statutes
Any provision in this policy that is in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Workers' Compensation Insurance
This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

HAZARDS INSURED AGAINST

This Section describes the hazards under which each Covered Person is insured and under which benefits provided by this Policy become payable. Any benefit is payable only once, even though more than one hazard may apply. Please read these and the *General Exclusions* sections in order to understand all of the terms, conditions and limitations of coverage.

SCHOOL ACTIVITIES HAZARD

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, when the Covered Person suffers a Covered Injury resulting directly and independently of all other causes from a Covered Accident that occurs while He is participating in or attending one of the following School Covered Activities:

1. regularly-scheduled classroom instruction;
2. regularly-scheduled and supervised recess or lunch period;
3. a study period or special instruction period supervised by a member of the School's faculty;
4. a Supervised and Sponsored School Activity;
5. field trips;
6. religious education;
7. any School event at which the Covered Person's attendance is required; or
8. Covered School Travel.

Covered School Travel includes travel, only within the United States, its possessions or the countries of Canada or Mexico and only directly and without interruption:

1. between Home and School;
2. between Home and another School or site designated by the School, where a School Supervised and Sponsored Activity is scheduled;
3. between the School or other meeting place designated by the School, and another School or site designated by the School, where a School Supervised and Sponsored Activity is scheduled.

Covered School Travel for Overnight Supervised and Sponsored School Activities
Covered School Travel also includes travel by any Common Carrier providing transportation to a Supervised and Sponsored School Activity, within *or* outside the United States, its possessions or the countries of Canada or Mexico when the Covered Person's participation in or attendance at it requires Him to be away from His Home for a stay of one or more nights. Coverage for travel to any Covered Activity that takes place outside the United States, its possessions or the countries of Canada or Mexico will be covered only if We have agreed to it in writing.

Definitions

For purposes of this hazard:

Supervised and Sponsored School Activity means a Covered Activity that:

1. takes place:
   a. on School premises during, before or after normal School hours; or
   b. at another School or site at which the Covered Activity is scheduled; and
2. is sponsored, organized or otherwise provided, or at which student attendance is required, by the School; and
3. is supervised by a member of the faculty or staff of the School, or by another adult specifically assigned supervisory duties and authority for that Covered Activity by the School
4. is a regularly-scheduled sports tryout, practice, workout or training session, team meeting, game, exhibition play or competition in which the Covered Person is participating.

Covered School Travel means transportation on:

1. a bus or Private Passenger Automobile driven by an adult with a valid drivers' license whom the School has specifically designated to transport Covered Persons to a Supervised and Sponsored School Activity; or
2. a Common Carrier chartered or otherwise contracted for by the School to provide Covered Persons with transportation to and from a Supervised and Sponsored School Activity.

Limitations

A Covered Person will not be protected under this hazard during:

1. travel to or from any Supervised and Sponsored School Activity if:
   a. the School provides transportation to and from it for a group of two or more Covered Persons; and
   b. the Covered Person is travelling to or from it by another means of transportation.
2. a Personal Deviation.
3. travel to any Covered Activity that takes place outside the United States, its possessions or the countries of Canada or Mexico unless We have agreed in advance to provide it.

DESCRIPTION OF ACCIDENT INDEMNITY BENEFITS

This Section describes the Accident Indemnity Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the *General Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these Benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Losses

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits,* subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits.*

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, We will pay the Benefit for the Covered Loss for which the largest benefit is payable.

If a Covered Accident causes the Covered Person's death, the total of all Benefits We will pay for Accidental Death and any other Covered Losses will not exceed the Principal Sum.

Definitions

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent inability to see with one or both eyes. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Severance means complete separation and dismemberment of the part from the body.

DESCRIPTION OF EXPENSE-INCURRED ACCIDENT BENEFITS

This Section describes the Scope of Coverage for which Medical Benefits are payable and the *Expense-Incurred Accident Benefits* provided by this Policy. Any applicable benefit percentages, benefit deductibles, benefit periods, benefit limits and maximums, are shown in the *Schedule of Benefits.* Please read these and the *General Exclusions* Sections in order to understand all of the terms, conditions and limitations applicable to these benefits.

SCOPE OF COVERAGE APPLICABLE TO EXPENSE-INCURRED MEDICAL BENEFITS

Covered Expenses and any applicable Deductibles are shown in the *Schedule of Benefits.*

Other Health Care Plan Benefits
When another Health Care Plan provides benefits in the form of services rather than cash payments, We will consider the reasonable cash value of such service in determining whether any Deductible has been satisfied, or any amount by which any benefit provided by this Policy will be reduced.

Full Excess Medical Expense
We will pay Covered Expenses:
1. after the Covered Person satisfies any Deductible; and
2. only when they are in excess of amounts payable by any other Health Care Plan whether or not claim has been made for benefits it provides.

We will pay benefits without regard to any Coordination of Benefits provision in such Health Care Plan.

ACCIDENT MEDICAL EXPENSE BENEFITS

We will pay the benefits shown in the *Schedule of Benefits* for Covered Expenses Incurred by the Covered Person, subject to all applicable conditions and exclusions, for Appropriate Treatment of a Covered Injury that resulted directly and independently of all other causes from a Covered Accident. Appropriate treatment of Covered Injuries sustained in a Covered Accident will include all medically necessary benefits mandated by New York Insurance Law.

Benefits will be paid:

1. when Covered Expenses Incurred exceed any applicable individual Deductible within the number of days from the date of the Covered Accident specified in the *Schedule of Benefits;* and
2. as long as the first Covered Expense has been Incurred within the number of days specified in the *Schedule of Benefits*; and
3. until any applicable Benefit Period shown in the *Schedule of Benefits* has expired; and
4. until the total of Covered Expenses paid equals any applicable Benefit Limit or Maximum Benefit shown in the *Schedule of Benefits*; and
5. until Benefits paid for all Covered Persons under the Policy equal the Total Maximum for Accident Medical Expense Benefits shown in the *Schedule of Benefits*.

A Covered Person has the right to appeal an adverse determination rendered by a utilization review agent pursuant to New York Insurance Law Article 49.

Covered Expenses

In-Patient Hospital Services

Room and Board Expenses – We will pay for:

1. confinement in an intensive care or coronary care unit, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of such confinement;
2. any other confinement, up to the maximum daily benefit shown in the *Schedule of Benefits* for each day of the Hospital Stay.

Miscellaneous Expenses – We will pay the Miscellaneous Expenses charged by a Hospital or an Ambulatory Medical or Surgical Center. Miscellaneous Expenses include, but are not limited to X-rays, CT Scans, MRIs, laboratory tests, in-hospital Physical Therapy, nurse services, orthopedic appliances, pre-admission tests, and all necessary charges other than room and board, for services received during:

1. a Hospital Stay; or
2. Out-Patient medical or surgical treatment.

Ambulatory Medical or Surgical Center

We will pay Covered Expenses Incurred for medical or surgical treatment provided in a licensed facility providing ambulatory medical or surgical treatment that is not a Hospital or Physician's office.

Emergency Room Treatment

We will pay Covered Expenses Incurred for Out-Patient emergency room treatment performed in a Hospital, up to the Maximum Benefit shown in the *Schedule of Benefits*. When emergency room treatment is immediately followed by admission to a Hospital, such treatment will be a Hospital Covered Expense.

Physician Services

We will pay Covered Expenses Incurred for Physician Services listed below.

Surgery

1. Covered Expenses charged for performing a Surgical Procedure. Two or more Surgical Procedures through the same incision will be considered as one procedure. However, We will pay up to 150% of the benefit for a Surgical Procedure when more than one Surgical Procedure through different operating fields is performed during the same surgical session.
2. Covered Expenses charged by an assistant surgeon assisting a Physician performing a Surgical Procedure.
3. Covered Expenses charged for treatment of fractured and dislocated bones, operations that involve cutting or incision and/or suturing of wounds or any other Surgical Procedure, including aftercare, which is given in the Out-Patient department of a Hospital or an Ambulatory Medical or Surgical Center.
4. Treatment provided by a Physician in an emergency room.
5. Any braces, splints or other devices required after surgery to ensure proper healing.

Anesthesia and its Administration – Covered Expenses charged by a Physician for anesthesia and its administration.

In-Hospital or Office Visits – Covered Expenses charged by a Physician for other than pre- or post-operative care, second or third opinion or consultation:
1. for in-Hospital visits; and
2. for office visits.

Out-Patient X-Rays

We will pay Covered Expenses Incurred for X-rays, except dental X-rays, performed on an Out-Patient basis at a Hospital or other licensed facility.

Out-Patient CT Scans & MRIs

We will pay Covered Expenses Incurred for CT Scans and MRIs performed on an Out-Patient basis at a Hospital or other licensed facility.

Out-Patient Laboratory Tests

We will pay Covered Expenses Incurred for laboratory tests performed on an Out-Patient basis at a Hospital or other licensed facility.

Out-Patient Physical Therapy

We will pay Covered Expenses Incurred for Out-Patient Physical Therapy. Physical Therapy includes: (a) acupuncture; (b) microthermy; (c) chiropractic adjustment; (d) manipulation; (e) diathermy; (f) massage therapy; (g) heat treatment; and (h) ultrasonic treatment.

Out-Patient Occupational and Speech Therapy

We will pay Covered Expenses Incurred for Out-Patient occupational and speech therapy required for rehabilitative treatment of a Covered Injury.

Nursing Services

We will pay Covered Expenses Incurred for services other than routine Hospital care, rendered by a Nurse.

Ambulance Services

We will pay Covered Expenses Incurred for ground or air ambulance service to transport the Covered Person from the place where the Covered Accident occurred to the nearest medically appropriate facility. We will pay Covered Expenses Incurred for ground or air ambulance transportation from the nearest medical facility to another appropriate medical facility, if a Physician specifies in writing that specialized care not available in the first facility to which the Covered Person was transported is necessary to treat his Covered Injury.

Covered Expenses will also include prehospital emergency medical services for the treatment of an emergency condition when provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health Law.

With respect to the payment of benefits for such services:
"Prehospital emergency medical services" means the prompt evaluation and treatment of an emergency medical condition, and/or non-air-borne transportation of the patient to a hospital, provided however, where the patient utilizes non-air-borne emergency transportation pursuant to this paragraph, reimbursement will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:
1. placing the health of the person affected with such condition in serious jeopardy;
2. serious impairment to such person's bodily functions;
3. serious dysfunction of any bodily organ or part of such person; or
4. serious disfigurement of such person.

"Emergency condition" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
1. placing the health of the person afflicted with such condition in serious jeopardy;
2. serious impairment to such person's bodily functions;
3. serious dysfunction of any bodily organ or part of such person; or

4. serious disfigurement of such person.

Medical Equipment Rental

We will pay Covered Expenses Incurred for rental or, if less, purchase of:

1. a wheelchair or hospital bed; or
2. other medical equipment that has permanent or temporary therapeutic value for the Covered Person and that can only be used by the Covered Person. Permanent or temporary therapeutic value must be certified by the Covered Person's treating Physician. Examples of items that are not covered include, but are not limited to: computers, motor vehicles and modifications thereof, ramps and installation costs, eyeglasses and hearing aids.

Prosthetic Devices

We will pay Covered Expenses Incurred for initial prosthetic devices, including their fitting, which are required in connection with treatment of a Covered Injury. Prosthetic devices and any benefit percentages and benefit limits are shown in the *Schedule of Benefits*. We will also pay for repair or replacement of prosthetic devices when damaged in a Covered Accident.

Dental Services

We will pay Covered Expenses Incurred for dental treatment, including X-rays, for injury to a tooth:

1. with no fillings or cavities or only fillings or cavities that do not undermine the tooth cusps; and
2. for which pulpal tissues are healthy and intact; and
3. for which periodontal tissue shows little or no signs of active or chronic inflammation. For insurance review purposes, each tooth unit is evaluated under these criteria rather than a blanket rating of the whole mouth.

Covered Expenses include examinations, x-rays, restorative treatment, endodontics, oral surgery, initial braces required for treatment of a Covered Injury and treatment of gingivitis resulting from trauma.

Covered Expenses must be incurred within the Benefit Period shown in the *Schedule of Benefits*. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted standards of the American Dental Association.

Prescription Drugs

We will pay the Covered Expenses Incurred for drugs that:

1. can only be obtained through a Physician's written prescription; and
2. are approved for such prescription use by the Federal Drug Administration (FDA).

We will also pay Covered Expenses Incurred for drugs that meet 1. above and are prescribed by a Physician for therapeutic use not specifically approved by the FDA.

The Covered Expense for a prescription drug is limited to the cost of a generic drug unless substitution of a generic drug is prohibited by law; no generic drug is available; or the Covered Person's Physician specifically requests that a non-generic drug be dispensed to the Covered Person.

Home Health Care

We will pay Covered Expenses Incurred for care and treatment rendered to a Covered Person by an agency possessing a valid certificate of approval or license issued pursuant to article thirty-six of the public health law, for the maximum number of visits shown in the *Schedule of Benefits* for:

1. part-time nursing or intermittent home nursing care by or under the supervision of a registered graduate nurse (R.N.);
2. part-time or intermittent home health aide services which consist primarily of caring for the patient;
3. physical, speech and occupational therapy if provided by the home health service or agency;
4. medical supplies, drugs and medications prescribed by a Physician, and laboratory services by or on behalf of a certified home health agency or licensed home health care services agency to the extent such items would have been covered if the Covered Person had been hospitalized or confined in a nursing facility as defined under subchapter XVIII of the Federal Social Security Act, 42 U.S.C. §§ 1395, et seq.

For the purpose of determining the number of Home Health Care visits payable, each visit by a member of a home health care team shall be considered as one Home Health Care Visit. Four hours of home health aide service shall also be considered as one Home Health Care visit.

Extended Care Facility

We will pay Covered Expenses Incurred by the Covered Person for treatment of a Covered Injury in an Extended Care Facility. Confinement in such Facility must:

1. be preceded by a Minimum Hospital Stay; and
2. begin within the number of consecutive days of a Minimum Hospital Stay, as specified in the *Schedule of Benefits*; and
3. include treatment for which a Physician visits the Covered Person at least once every 30 days.

General Limitations Applicable to Accident Medical Expense Benefits

Non-Duplication of Benefits

This provision applies if:

1. any other Health Care Plan covers the Covered Person; and
2. total benefits under all Plans would exceed the Covered Expenses actually incurred; and
3. We are not defined as primary under another Health Care Plan's Coordination of Benefits provision.

When the total of benefits payable by all Health Care Plans, whether or not claim is made for those benefits, exceeds Covered Expenses incurred, any Expense-Incurred Accident Benefits We pay will be reduced by such excess.

Non-Duplication of Benefits When This Policy and Other Plans Are Excess

This provision applies if benefits under any other Health Care Plan are covered under this Policy, and coverage under this Policy and the other Plan are excess.

We pay a pro rata share of the total amount of Covered Expenses. In no case will the total benefits payable exceed 100% of the Covered Expenses.

Our pro rata share equals the total of benefits payable under this Policy multiplied by a fraction, of which the numerator is the benefits We pay and the denominator is the total of benefits payable by all Health Care Plans for the same Covered Accident.

Multiple Coverages

The Covered Person is not eligible for blanket accident insurance under more than one policy issued by Us. If premium is being paid under more than one such policy, insurance will be in effect under the policy providing the greatest benefit, and premium paid under any other policies will be refunded.

Limitations.

None of the following will be considered Covered Expenses unless coverage is specifically provided.

1. Rest care or rehabilitative care and treatment, custodial care and transportation.
2. Cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to:
   a. cosmetic surgery resulting from a Covered Accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Covered Accident;
   b. reconstruction incidental to or following surgery resulting from a Covered Accident.
3. Any elective or routine treatment, surgery, health treatment or examinations that are not related to the treatment of a Covered Accident.
4. Routine eye examinations or the fitting of eyeglasses or contact lenses.
5. Hearing examinations or the fitting of hearing aids.
6. Dental examinations or dental care unless resulting from a Covered Accident.
7. Treatment of injury resulting from a condition that a Covered Person knew existed on the date of a Covered Accident, unless we have received a written medical release from his Physician.

Right to Appeal of Adverse Determinations by Utilization Review Agents

A Covered Person, a Covered Person's designee and, in connection with concurrent and retrospective Adverse Determinations, a Covered Person's Health Care Provider, shall have the right to request an External Appeal in the following situations.

A. When:

1. A Covered Person has had coverage of a Health Care Service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such Health Care Plan's service does not meet the Health Care Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; and
2. the Health Care Plan has rendered a Final Adverse Determination with respect to such Health Care Service or both the plan and the Covered Person have jointly agreed to waive any internal appeal, or the Covered Person is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19,

or

B. When:

1. A Covered Person has had coverage of a Health Care Service denied on the basis that such service is experimental or investigational, and such denial has been upheld on appeal, or both the plan and the Covered Person have jointly agreed to waive any internal appeal, or the Covered Person is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Federal Public Health Service Act, 42 U.S.C. § 300gg-19; and
2. A Covered Person's attending Physician has certified that the Covered Person has a condition or disease:
   a. for which standard health services or procedures have been ineffective or would be medically inappropriate; or
   b. for which there does not exist a more beneficial standard health service or procedure covered by the Health Care Plan; or
   c. for which there exists a Clinical Trial or Rare Disease treatment, and
3. The Covered Person's attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the area of practice appropriate to treat the Covered Person's condition or disease, must have recommended either:
   a. a health service or procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph two of subdivision (e) of section forty-nine hundred of article forty-nine of the New York Insurance Law) that, based on two documents from the available Medical and Scientific Evidence, is likely to be more beneficial to the Covered Person than any covered standard health service or procedure or, in the case of a Rare Disease, based on the Physician's certification and such other evidence as the Covered Person, the Covered Person's designee or the Covered Person's attending Physician may present, that the requested health service or procedure is likely to benefit the Covered Person in the treatment of the Covered Person's Rare Disease and that such benefit to the Covered Person outweighs the risks of such health service or procedure; or
   b. a Clinical Trial for which the Covered Person is eligible. Any Physician certification provided shall include a statement of the evidence relied upon by the Physician in certifying his or her recommendation, and
4. the specific health service or procedure recommended by the attending Physician would otherwise be covered under the policy except for the Health Care Plan's determination that the health service or procedure is experimental or investigational,

or

C. When:

1. A Covered Person has had coverage of the health service (other than a Clinical Trial), which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal, in whole or in part, on the grounds that such health service is out-of-network and an alternate recommended health service is available in-network, and the health plan has rendered a Final Adverse Determination with respect to an Out-of-

Network Denial or both the health plan and the Covered Person have jointly agreed to waive any internal appeal; and

2. The Covered Person's attending Physician, who shall be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat the Covered Person for the health service sought, certifies that the out-of-network health service is materially different than the alternate recommended in-network service, and recommends a Health Care Service that, based on two documents from the available Medical and Scientific Evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.

Procedure for External Appeals of Adverse Determinations

A. A Covered Person shall have four months to initiate an External Appeal after the Covered Person receives notice from the Health Care Plan, or such plan's Utilization Review Agent if applicable, of a Final Adverse Determination or denial or after both the plan and the Covered Person have jointly agreed to waive any internal appeal, or after the Covered Person is deemed to have exhausted or is not required to complete any internal appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19. Where applicable, the Covered Person's Health Care Provider shall have sixty days to initiate an External Appeal after the Covered Person or the Covered Person's Health Care Provider, as applicable, receives notice from the Health Care Plan, or such plan's Utilization Review Agent if applicable, of a Final Adverse Determination or denial or after both the plan and the Covered Person have jointly agreed to waive any internal appeal. Such request shall be in writing. The Covered Person, and the Covered Person's Health Care Provider where applicable, shall have the opportunity to submit additional documentation with respect to such appeal to the External Appeal Agent within such the applicable time period above; provided however that when such documentation represents a material change from the documentation upon which the Utilization Review Agent based its Adverse Determination or upon which the health plan based its denial, the health plan shall have three business days to consider such documentation and amend or confirm such Adverse Determination.

B. The External Appeal Agent shall make a determination with regard to the appeal within thirty days of the receipt of the request therefor. The External Appeal Agent shall have the opportunity to request additional information from the Covered Person, the Covered Person's Health Care Provider and the Covered Person's Health Care Plan within such thirty-day period, in which case the agent shall have up to five additional business days if necessary to make such determination. The External Appeal Agent shall notify the Covered Person, the Covered Person's Health Care Provider where appropriate, and the Health Care Plan, in writing, of the appeal determination within two business days of the rendering of such determination.

C. Notwithstanding the provisions of the paragraphs A and B above, if the Covered Person's attending Physician states that a delay in providing the Health Care Service would pose an imminent or serious threat to the Covered Person's health, or if the Covered Person is entitled to an expedited external appeal pursuant to section 2719 of the Public Health Service Act, 42 U.S.C. § 300gg-19, the External Appeal shall be completed within no more than seventy-two hours of the request therefor and the External Appeal Agent shall make every reasonable attempt to immediately notify the Covered Person, the Covered Person's Health Care Provider where appropriate, and the health plan of its determination by telephone or facsimile, followed immediately by written notification of such determination.

D. The Health Care Plan may charge the Covered Person a fee of up to twenty-five dollars per External Appeal with an annual limit on filing fees for each Covered Person not to exceed seventy-five dollars within a single plan year; provided that, in the event the External Appeal Agent overturns the Final Adverse Determination of the plan, such fee shall be refunded to the Covered Person. Notwithstanding the foregoing, the health plan shall not require a Covered Person to pay any such fee if the Covered Person is a recipient of medical assistance or if the Covered Person is covered by a policy pursuant to title one-A of article twenty-five of the public health law (the Children's Health Insurance Plan). Notwithstanding the foregoing, the health plan shall not require a Covered Person to pay any such fee if such fee shall pose a hardship to the Covered Person as determined by the plan.

E. The Health Care Plan may charge the Covered Person's Health Care Provider a fee of up to fifty dollars per External Appeal, other than for an External Appeal requested pursuant to paragraph (2) or (3) of subsection (d) of section forty-nine hundred fourteen of the New York Insurance Law; provided that, in the event the External Appeal Agent overturns the Final Adverse Determination of the plan, such fee shall be refunded to the Covered Person's Health Care Provider.

F. A Covered Person covered under the Medicare or Medicaid program may appeal the denial of a Health Care Service pursuant to the provisions of Title 2 of Article 49 of the New York Insurance Law, provided, however, that any determination rendered concerning such denial pursuant to existing federal and state law relating to the Medicare or Medicaid program or pursuant to federal law enacted subsequent to the effective date of Title 2 of Article 49 of the New York Insurance Law and providing for an External Appeal process for such denials shall be binding on the

Covered Person and the insurer and shall supersede any determinations rendered pursuant to Title 2 of Article 49 of the New York Insurance Law.

G. Except as provided in paragraphs H. and I. below, payment for an external appeal shall be the responsibility of the Health Care Plan. The Health Care Plan shall make payment to the External Appeal Agent within forty-five days, from the date the appeal determination is received by the Health Care Plan, and the Health Care Plan shall be obligated to pay such amount together with interest thereon calculated at a rate which is the greater of the rate set by the commissioner of taxation and finance for corporate taxes or twelve percent per annum, to be computed from the date the bill was required to be paid, in the event that payment is not made within such forty-five days.

H. If the Covered Person's Health Care Provider requests an External Appeal of a concurrent Adverse Determination and the External Appeal Agent upholds the Health Care Plan's determination in whole, payment for the External Appeal shall be made by the Health Care Provider in the manner and subject to the timeframes and requirements set forth in paragraph G. above.

I. If the Covered Person's Health Care Provider requests an External Appeal of a concurrent Adverse Determination and the External Appeal Agent upholds the Health Care Plan's determination in part, payment for the External Appeal shall be evenly divided between the Health Care Plan and the Covered Person's Health Care Provider who requested the External Appeal and shall be made by the Health Care Plan and the Covered Person's Health Care Provider in the manner and subject to the timeframes and requirements set forth in paragraph G. above; provided, however, that the Superintendent may, upon a determination that Health Care Plans or Health Care Providers are experiencing a substantial hardship as a result of payment for the External Appeal when the External Appeal Agent upholds the Health Care Plan's determination in part, in consultation with the commissioner of health, promulgate regulations to limit such hardship.

J. If the Covered Person's Health Care Provider was acting as the Covered Person's designee, payment for the External Appeal shall be made by the Health Care Plan. The External Appeal and any designation shall be submitted on a standard form developed by the Superintendent in consultation with the commissioner of health. The Superintendent shall have the authority upon receipt of an External Appeal to confirm the designation or request other information as necessary, in which case the Superintendent shall make at least two written requests to the Covered Person to confirm the designation. The Covered Person shall have two weeks to respond to each such request. If the Covered Person fails to respond to the Superintendent within the specified timeframe, the Superintendent shall make two written requests to the Health Care Provider to file an External Appeal on his or her own behalf. The Health Care Provider shall have two weeks to respond to each such request. If the Health Care Provider does not respond to the Superintendent's requests within the specified timeframe, the Superintendent shall reject the appeal. If the Health Care Provider responds to the Superintendent's requests, payment for the External Appeal shall be made in accordance with paragraphs H. and I. above.

Definitions

For the purposes of this section describing the External Appeals Process, the following definitions apply.

Adverse Determination means a determination by a Utilization Review Agent that an admission, extension of stay, or other Health Care Service, upon review based on the information provided, is not medically necessary.

Clinical Peer Reviewer means:

1. a Physician who:
   a. possesses a current and valid non-restricted license to practice medicine;
   b. where applicable, is board-certified or board-eligible in the same or similar specialty as the Health Care Provider who typically manages the medical condition or disease or provides the Health Care Service or treatment under appeal;
   c. has been practicing in such area of specialty for a period of at least five years; and
   d. is knowledgeable about the Health Care Service or treatment under appeal; or
2. a Health Care Professional other than a licensed Physician who:
   a. where applicable, possesses a current and valid non-restricted license, certificate or registration;
   b. where applicable, is credentialed by the national accrediting body appropriate to the profession in the same profession and same or similar specialty as the Health Care Provider who typically manages the medical condition or disease or provides the Health Care Service or treatment under appeal;
   c. has been practicing in such area of specialty for a period of at least five years;
   d. is knowledgeable about the Health Care Service or treatment under appeal; and
   e. where applicable to such Health Care Professional's scope of practice, is clinically supported by a Physician who possesses a current and valid non-restricted license to practice medicine.

Clinical Trial means a peer-reviewed study plan which has been:
1. reviewed and approved by a qualified institutional review board, and
2. approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

As used in this definition, the term Cooperative Groups means formal networks of facilities that collaborate on research projects and have established NIH-approved peer review programs operating within their groups, and that include, but are not limited to, the National Cancer Institute (NCI) Clinical Cooperative Groups, the NCI Community Clinical Oncology Program (CCOP), the AIDS Clinical Trials Groups (ACTG), and the Community Programs for Clinical Research in AIDS (CPCRA).

External Appeal means an appeal conducted by an External Appeal Agent in accordance with the provisions of section four thousand nine hundred fourteen of the New York Insurance Law.

External Appeal Agent means an entity certified by the Superintendent pursuant to section four thousand nine hundred eleven of the New York Insurance Law.

Final Adverse Determination means an Adverse Determination, which has been upheld by a Utilization Review Agent with respect to a proposed Health Care Service following a standard appeal, or an expedited appeal where applicable, pursuant to section four thousand nine hundred four of the New York Insurance Law.

Health Care Plan means an insurer subject to article forty-two or forty-three of the New York Insurance Law, or any organization licensed under article forty-three of the New York Insurance Law.

Health Care Professional means an appropriately licensed, registered or certified Health Care Professional pursuant to title eight of the education law or a Health Care Professional comparably licensed, registered or certified by another state.

Health Care Provider means a Health Care Professional or a facility licensed pursuant to articles twenty-eight, thirty-six, forty-four or forty-seven of the public health law or a facility licensed pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law.

Health Care Service means:
1. health care procedures, treatments or services:
   a. provided by a facility licensed pursuant to article twenty-eight, thirty-six, forty-four or forty-seven of the public health law or pursuant to article nineteen, twenty-three, thirty-one or thirty-two of the mental hygiene law; or
   b. provided by a Health Care Professional; and
2. the provision of pharmaceutical products or services or durable medical equipment.

Health Care Services shall also mean experimental or investigational procedures, treatments or services, including:
1. services provided within a Clinical Trial, and
2. the provision of a pharmaceutical product pursuant to prescription by the Covered Person's attending Physician for a use other than those uses for which such pharmaceutical product has been approved for marketing by the federal Food and Drug Administration; to the extent that coverage for such services are prohibited by law from being excluded under the plan. Provided that nothing described in this paragraph 2. shall be construed to define what are covered services pursuant to a subscriber contract or governmental health benefit program.

Material Financial Affiliation means any financial interest of more than five percent of total annual revenue or total annual income of an External Appeal Agent or officer, director, or management employee thereof; or Clinical Peer Reviewer employed or engaged thereby to conduct any External Appeal. This term shall not include revenue received from a Health Care Plan by:
1. an External Appeal Agent to conduct an External Appeal pursuant to section forty-nine hundred fourteen of title two of article forty-nine of the New York Insurance Law, or
2. a Clinical Peer Reviewer for health services rendered to Covered Persons.

Material Professional Affiliation means any Physician-patient relationship, any partnership or employment relationship, a shareholder or similar ownership interest in a professional corporation, or any independent contractor arrangement that constitutes a Material Financial Affiliation with any expert or any officer or director of the independent organization.

Medical and Scientific Evidence means the following sources:

1. peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;
3. peer-reviewed abstracts accepted for presentation at major medical association meetings;
4. peer-reviewed literature shall not include publications or supplements to publications sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer;
5. medical journals recognized by the secretary of Health and Human Services, under section 1861 (t)(2) of the federal Social Security Act;
6. the following standard reference compendia:
   a. the American Hospital Formulary Service - Drug Information;
   b. the National Comprehensive Cancer Network's Drugs and Biologics Compendium;
   c. the American Dental Association Accepted Dental Therapeutics;
   d. Thomson Micromedex DrugDex; and
   e. Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services (CMS); or recommended by review article or editorial comment in a major peer reviewed professional journal;
7. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

Out-of-Network Denial means a denial of a request for pre-authorization to receive a particular health service from an out-of-network provider on the basis that such out-of-network health service is not materially different than the health service available in-network. The notice of an Out-of-Network Denial provided to a Covered Person shall include information explaining what information the Covered Person must submit in order to appeal the Out-of-Network Denial pursuant to subsection (a-1) of section four thousand nine hundred four of Title I, article forty-nine of the New York Insurance Law. An Out-of-Network Denial does not constitute an Adverse Determination as defined above. Notwithstanding any other provision of previously cited subsection, an Out-of-Network Denial shall not be construed to include a denial for a referral to an out-of-network provider on the basis that a Health Care Provider is available in-network to provide the particular health service requested by the Covered Person.

Rare Disease means a condition or disease that:

1. is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network or affects fewer than two hundred thousand United States residents per year; and

2. for which there does not exist a standard health service or procedure covered by the Health Care Plan that is more clinically beneficial than the requested health service or treatment.

A Physician, other than the Covered Person's treating Physician, shall certify in writing that the condition is a Rare Disease as defined herein. The certifying Physician shall be a licensed, board-certified or board-eligible Physician who specializes in the area of practice appropriate to treat the Covered Person's Rare Disease. The certification shall provide either:

1. that the Covered Person's Rare Disease is currently or has been subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network; or

2. that the Covered Person's Rare Disease affects fewer than two hundred thousand United States residents per year.

The certification shall rely on Medical and Scientific Evidence to support the requested health service or procedure, if such evidence exists, and shall include a statement that, based on the Physician's credible experience, there is no standard treatment that is likely to be more clinically beneficial to the Covered Person than the requested health service or procedure and the requested health service or procedure is likely to benefit the Covered Person in the treatment of the Covered Person's Rare Disease and that such benefit to the Covered Person outweighs the risks of such health service or procedure. The certifying Physician shall disclose any Material Financial or Professional Affiliation with the provider of the requested health service or procedure as part of the application for External Appeal of denial of a Rare Disease treatment. If the provision of the requested health service or procedure at a health care facility requires prior approval of an institutional review board, the Covered Person or the Covered Person's designee shall also submit such approval as part of the External Appeal application.

Superintendent means the Superintendent of Financial Services.

Utilization Review means the review to determine whether Health Care Services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. For the purposes of article forty-nine of the New York Insurance Law, none of the following shall be considered Utilization Review:

1. denials based on failure to obtain Health Care Services from a designated or approved Health Care Provider as required under a subscriber's contract;
2. where any determination is rendered pursuant to subdivision three-a of section twenty-eight hundred seven-c of the New York Public Health Law;
3. the review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure;
4. any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an adverse determination; and
5. any determination of any coverage issues other than whether Health Care Services are or were medically necessary.

Utilization Review Agent means any insurer subject to article thirty-two or forty-three of the New York Insurance Law and any municipal cooperative health benefit plan certified pursuant to article forty-seven of the New York Insurance Law performing Utilization Review and any independent Utilization Review Agent performing Utilization Review under contract with such insurer or municipal cooperative health benefit plan.

APPENDIX B
STUDENT ACCIDENT INSURANCE INFORMATION SHEET

A) ESTIMATED ENROLLMENT:

BASIC STUDENT:

Pre-K:	138
Grades K-8:	3772
Grades 9-12:	1999
Adult Ed (if covered):	600/year
Average Daily Attendance:	95%

FOOTBALL (HIGH SCHOOL ONLY):

Tryouts: JV= 45 Varsity =45
Finals: JV=45 Varsity=45

B) DESCRIPTION OF PRESENT PLAN:

NAME OF INSURANCE COMPANY: Pupil Benefits

BASIC STUDENT BENEFITS:

Medical Maximum:	$50,000
Deductible:	NO
Death Benefit:	$ 5,000

FOOTBALL BENEFITS: YES

C) RATE STRUCTURE FOR CURRENT PLAN:

BASIC STUDENT:

Pre-K:	$12.52
Grades K-8:	$12.52
Grades 9-12:	$12.52
Adult Ed (if covered):	No additional Charge

FOOTBALL (HIGH SCHOOL ONLY):

Tryouts: No additional charge
Finals: No additional charge

D)

Premium & Claims Experience	Premium		# of Claims	Total $ Amount
2022-2023	72,853			
2021-2022	67,978			
2020-2021	63,343			
2019-2020	62,252			

E) CATASTROPHIC COVERAGE: YES

Limit- $5,000,000 Premium- $6,098

Summer Sports Camp Insurance-Included

APPENDIX C
PREMIUM SUMMARY SHEET

This section shall include the proposed cost to provide the insurance coverage requested, that is, for each of the categories specified, and an annual total cost. Appendix B lists the coverage needed. Include any other costs and price information that would be contained in a potential agreement with the District. No other cost such as commissions or brokerage fees will be considered if not included in the cost proposal. The per student rate times the enrollment will be the premium. The total premium cost shall be indicated on Appendix C, "Premium Summary Sheet".

Name of Provider: _____

Contact Name and Title: _____

Address: _____

Telephone # _____ Fax #_____

Website/E-Mail: _____

Type(s) of Service and Rate Information that would be included in a potential agreement with the District (or attach rate sheet):

DESCRIPTION	RATE STRUCTURE				
	2023-2024	2024-2025	2025-2026	2026-2027	2027-2028
PRE-K per student					
GRADES K-8 per student					
GRADES 9-12 per student					
ADULT ED					
FOOTBALL TRYOUTS					
FOOTBALL FINALS					
CATASTROPHIC ($5,000,000 COVERAGE)					
SUMMER SPORTS CAMP					

_____ SIGNATURE

_____ DATE

SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT
60 Weston Street, Huntington Station, NY 11746

GENERAL CONDITIONS
(For the purchase of materials, supplies, and equipment)

All invitations to bid issued by the above named school district will bind bidders and successful bidders to the conditions and requirements set forth in these general conditions, and such conditions shall form an integral part of each purchase contract awarded by the school district.

DEFINITIONS

"School District"	- shall be the legal designation of the district
"Notice to Bidders"	- a formal statement which, when issued by the school district, constitutes an invitation to bid on the materials, supplies, and equipment described by the specifications.
"Board"	- the Board of Education of the school district.
"Bid"	- an offer to furnish materials, supplies, and/or equipment in accordance with the invitation to bid, the general conditions, special instructions, and the specifications.
"Bid Offer"	- the form on which the bidder submits his bid.
"Bidder"	- any individual, company or corporation submitting a bid.
"Contract"	- a notice to the successful bidder by the issuance of a purchase order; also all documents relating to the transaction, including but not limited to, the bid offer of the successful bidder, notice to bidders, general information, general conditions, special instructions, specification, notice of award, bid proposal certification; also a formal document signed by the successful bidder and the school district representative.
"Successful bidder"	- any bidder to whom an award is made by the school district.
"Contractor"	-any bidder to whom a contract award is made by the board of education.
"Specification"	-description of materials, supplies, and/or equipment and the conditions for its purchase.

BIDS

1. The date, time, and place of bid opening will be given in the Notice to Bidders.

2. All bids must be submitted on bid offer forms and in accordance with instructions provided by the board.

3. All bids received after the time stated in the Notice to Bidders may not be considered and will be returned unopened to the bidder. The bidder assumes the risk of any delay in the mail or in the handling of the mail by employees of the school district. Whether sent by mail or by means of personal delivery, the bidder assumes responsibility for having his bid deposited on time at the place specified.

4. All information that is required by Notice to Bidders, General Conditions, Specifications, and Bid Offer, in connection with each item against which a bid is submitted, must be given to constitute a regular bid.

5. The non-collusive bidding certification must be included with each bid as required by General Municipal Law, Section 103-d.

6. The submission of a bid will be construed to mean that the bidder is fully informed as to the extent and character of the service, supplies, materials, or equipment required and a representation that the bidder can furnish the service, supplies, materials, or equipment satisfactorily in complete compliance with the specifications.

7. No alteration, erasure, or addition is to be made in the typewritten or printed matter. Deviations from the specifications must be set forth in space provided in bid for this purpose.

8. Prices and information required should be typewritten for legibility. Illegible or vague bids may be rejected. All signatures must be written. Facsimile, printed, or typewritten signatures are not acceptable.

9. Sales to school districts are not affected by any fair trade agreements. (General Business Law, Sec. 369-a, sub. 3).

10. No charge will be allowed for Federal, State, or municipal sales and excise taxes since the school district is exempt from such taxes. The price bid shall be net and shall not include the amount of any such tax.

11. In all specifications, the words "or equal" are understood after each article giving manufacturer's name or catalog reference, or on any patented article. The decision of the School district as to whether an alternate or substitution is in fact "equal" shall be final. If bidding on items other than those specified, bidder must in every instance give the trade designation of the article, manufacturer's name, and detailed specifications of item he proposes to furnish. Otherwise, bid will be construed as submitted on the identical item as specified.

12. Bids on equipment must be on standard new equipment, of latest model and in current production, unless otherwise specified.

13. All regularly manufactured stock electrical items must bear the label of the Underwriters' Laboratories, Inc.

14. When bids are requested on a lump sum basis, bidder must bid on each item in the lump sum group. A bidder desiring to bid "no charge" on an item in a group must so indicate; otherwise bid for the group may be rejected.

15. All prices quoted must be "per unit" as specified; e.g., do not quote "per case" when "per dozen" is requested; otherwise, bid may be rejected.

16. Bidder must insert the price per unit and the extensions against each item in his bid. In the event of a discrepancy between the unit price and the extension, the unit price will govern. Prices shall be extended in decimals, not fractions.

17. Prices shall be net, including transportation and delivery charges fully prepaid by the successful bidder to destination indicated in the instructions to bidders. If award is made on any other basis, transportation charges must be prepaid by the successful bidder and added to the invoice as a separate item. In any case, title shall not pass until items have been delivered and accepted.

18. All bids must be sealed. They must be submitted in envelopes furnished by the school district, if any. Otherwise, plain, opaque envelopes may be used, clearly marked "BID." Also the date and time of the bid opening as indicated on the Notice to Bidders must appear on the envelope. Bids must not be attached to or enclosed in packages containing bid samples. Telephoned quotations or amendments will not be accepted at any time.

19. No interpretation of the meaning of the specifications or other contract document will be made to any bidder orally. Every request for such interpretation should be in writing, addressed to the school district, not later than five (5) days prior to the date fixed for the opening of bids. Notice of any and all such interpretations and any supplemental instructions will be sent to all bidders of record by the school district in the form of addenda to the specifications. All addenda so issued shall become a part of the contract documents.

20. If the supplies, materials, or equipment are to be delivered over an extended period of time, or if the specifications so state, then the successful bidder may be required to execute an agreement in relation to the performance of his contract, such agreement to be executed by the bidder within 15 days after notification to execute such contract. If the specifications so state, the successful bidder also may be required to furnish a performance bond equal to the full amount of the contract to guarantee the faithful performance of such contract. Such performance bond shall be maintained in full force and effect until the contract shall have been fully performed. The Surety Company furnishing such performance bond shall be authorized to do business in the State of New York and must be satisfactory to the school district. The successful bidder shall execute the performance bond at the time of the execution of the contract by the successful bidder and the board.

SAMPLES

21. All specifications are minimum standards; and accepted bid samples do not supersede specification for quality unless bid sample is superior, in which case deliveries must be the same identity and quality as accepted bid sample.

22. The school district reserves the right to request a representative sample of the item quoted upon either prior to the award or before shipments is made. If the sample is not in accordance with the requirements of the specification, the school district may reject the bid; or, if award has been made, cancel the contract at the expense of the successful bidder.

23. Samples, when required, must be submitted strictly in accordance with instructions; otherwise, bid may not be considered. If samples are requested subsequent to bid opening, they shall be delivered as directed for bid to have consideration. Samples must be furnished free of charge and must be accompanied by descriptive memorandum invoices indicating if the bidder desires their return and specifying the address to which they are to be returned provided they have not been used or made useless by tests. Award samples may be held for comparison with deliveries. The school district will not be responsible for any samples destroyed or mutilated by examination or testing. The bidder at his expense shall remove samples. Samples not removed within fifteen (15) days after written notice to the bidder will be regarded as abandoned and the school district shall have the right to dispose of them as its own property.

24. When a specification indicates that an item to be purchased is to be equal to a sample, such sample will be on display at a designated location in the school district. Failure on the part of the bidder to examine sample shall not entitle him to any relief from the conditions imposed in the proposal, specification, etc.

AWARD

25. Awards will be made to the lowest responsible bidder, as will best promote the public interest, taking into consideration the reliability of the bidder, the quality of the materials, equipment, or supplies to be furnished, their conformity with the specifications, the purposes for which required, and the terms of delivery.

26. The school district reserves the right to reject all bids. Also reserved is the right to reject, for cause, any bid in whole or in part to waive technical defects, qualifications, irregularities, and omissions, if in its judgment the best interests of the district will be served. Also reserved is the right to reject bids and to purchase items on State, County, BOCES, Municipal or Consortium contracts if such items can be obtained on the same terms, conditions, specifications, and at a lower price.

27. The school district reserves the right to make awards within sixty (60) days after the date of the bid opening during which period bids may not be withdrawn unless the bidder distinctly states in his bid that acceptance thereof must be made within a shorter specified time.

28. Where a bidder is requested to submit a bid on individual items and also on a total sum or sums, the right is reserved to award contracts on individual items and also on a total sum or sums, whichever is in the best interests of the School district.

29. If two or more bidders submit identical bids as to price, the decision of the board to award a contract to one of such identified bidders shall be final. (General Municipal Law, Sec. 103, sub. 1.)

CONTRACT

30. Each bid will be received with the understanding that the acceptance thereof in writing by the board, to furnish any or all of the items described therein shall constitute a contract between the successful bidder and the school district. Contract shall bind the successful bidder on his part to furnish and deliver at the prices and in accordance with the conditions of his bid. Contract shall bind the school district on its part to order from such successful bidder and to pay for at the contract prices, all items ordered and delivered, within ten (10) percent over or under the award quantity, unless otherwise specified.

31. The placing in the mail of a notice of award or purchase order to a successful bidder, to the address given in his bid, will be considered sufficient notice of acceptance of contract.

32. If the successful bidder fails to deliver as ordered, or within the time specified, or within reasonable time as interpreted by the school district, or fails to make replacement of rejected articles, when so requested immediately or as directed by the school district, the school district may purchase from other sources to take the place of the item rejected or not delivered. The school district reserves the right to authorize immediate purchase from other sources against item rejections or not delivered on any contract when necessary. On all such purchases the successful bidder agrees to reimburse the school district promptly for excess costs occasioned by such purchases. Should the cost be less, the successful bidder shall have no claim to the difference. Such purchases will be deducted from contract quantity.

33. A contract may be canceled at the successful bidder's expense upon nonperformance of contract.

34. Cancellation of contract for any reason may result in removal of the successful bidder's name from mailing list for future proposals for an indeterminate period.

35. When materials, equipment, or supplies are rejected, the successful bidder from the premises of the school district must remove them within ten (10) days of notification. Rejected items left longer than ten (10) days will be regarded as abandoned, and the school district shall have the right to dispose of them as its own property.

36. No items are to be shipped or delivered until receipt of an official purchase order from the school district.

37. It is mutually understood and agreed that the successful bidder shall not assign, transfer, convey, sublet, or otherwise dispose of the contract or his right, title, or interest therein, or his power to execute such contract, to any other person, company, or corporation, without the previous written consent of the school district.

INSTALLATION OF EQUIPMENT

38. The successful bidder shall clean up and remove all debris and rubbish resulting from his work from time to time as required or directed. Upon completion of the work the premises shall be left in a neat, unobstructed condition, and the buildings broom cleaned, and everything in perfect repair and order. Old materials are the property of the successful bidder unless otherwise specified.

39. Equipment, supplies, and materials shall be stored at the site, only on the approval of the school district and at the successful bidder's risk. In general, such on-site storage

should be avoided to prevent possible damage or loss of the material.

40. Work shall be progressed so as to cause the least inconvenience to the school district and with proper consideration for the rights of other successful bidders or workmen. The successful bidder shall keep in touch with the entire operation and install his work promptly.

41. Bidders shall acquaint themselves with conditions to be found at the site and shall assume all responsibility for placing and installing the equipment in the locations required.

42. Equipment for trade-in shall be dismantled by the successful bidder and removed at his expense. The condition of the trade-in equipment at the time it is turned over to the successful bidder shall be the same as covered in the specifications, except as affected by normal wear and tear from use up to the time of trade-in. All equipment is represented simply "as is." Equipment is available for inspection only at the delivery point listed for new equipment, unless otherwise specified.

GUARANTEES BY THE SUCCESSFUL BIDDER

43.The successful bidder guarantees:

a) His products against defective material or workmanship and to repair or replace any damages or marring occasioned in transit.
b) To furnish adequate protection from damage for all work and to repair damages of any kind for which he or his workmen are responsible, to the building or equipment, to his own work, or to the work of other successful bidders.
c) To carry adequate insurance to protect the school district from loss in case of accident, fire, theft, etc.
d) The contractor shall, during the term of the contract including any warranty period, indemnify, defend, and hold harmless the School district, it's officials, employees, agents, and representatives thereof from all suits, actions or claims of any kind , including attorney's fees, brought on account of any personal injuries , damages, or violations of rights, sustained by any person or property in consequence of any neglect in safeguarding contract work or on account of any act or omission by the contractor or his employees, or from any claims or amounts arising from violation of any law, bylaw, ordinance, regulation or decree. The vendor agrees that this clause shall include claims involving infringement of patent or copyright.
e) That all deliveries will be equal to the accepted bid sample.
f) That the equipment delivered is standard, new, latest model of regular stock product or as required by the specifications; also that no attachment or part has been substituted or applied contrary to manufacturer's recommendations and standard practice. Every unit delivered must be guaranteed against faulty material and workmanship for a period of at least one year from date of delivery. If during this period such faults develop, the successful bidder agrees to replace the unit or the part affected without cost to the school district.

Any merchandise provided under the contract, which is or becomes defective during the guarantee period shall be replaced by the successful bidder free of charge with the specific understanding that all replacements shall carry the same guarantee as the original equipment. The successful bidder shall make any such replacement immediately upon receiving notice from the school district.

DELIVERY

44. Delivery must be made in accordance with the instructions to bidders and specifications. If delivery instructions do not appear on order, it will be interpreted to mean prompt delivery. The decision of the school district as to reasonable compliance with delivery term shall be final.

45. The school district will not accept any deliveries on Saturday, Sundays, or legal holidays, except commodities required for daily consumption or where the delivery is for an emergency.

46. Items shall be securely and properly packed for shipment, storage, and stocking in shipping containers and according to acceptable commercial practice, without extra charge for packing cases, baling or sacks.

47. The successful bidder shall be responsible for the delivery of items in good condition at point of destination . He shall file with the carrier all claims for breakage, imperfections, and other losses, which will be deducted from invoices. The receiving School district will note for the benefit of successful bidder when packages are not received in good condition.

48. Unless otherwise stated in the specifications, all items must be delivered into and placed at a point within the building as directed by the shipping instructions or the agent for the school district. The successful bidder will be required to furnish proof of delivery in every instance.

49. Unloading and placing of the equipment and furniture is the responsibility of the successful bidder, and the school district accepts no responsibility for unloading and placing of equipment. Any costs incurred due to the failure of the successful bidder to comply with this requirement will be charged to him. No help for unloading will be provided by the school district, and suppliers should notify their truckers accordingly.

50. All deliveries shall be accompanied by delivery tickets or packing slips. Ticket shall contain the following information for each item delivered:

Contract Number and/or Purchase Order Number
Name of Article
Item Number (if applicable)
Quantity
Name of the Successful Bidder

Carton shall be labeled with purchase order or contract number, successful bidder's name and general statement of contents. Failure to comply with this condition shall be considered sufficient reason for refusal to accept the goods.

PAYMENTS

51. Payment for the used portion of an inferior delivery will be made by the school district on an adjusted price basis.

52. Payment will be made only after correct presentation of claim form or invoices as may be required.

53. Payments of any claim shall not preclude the school district from making claim for adjustment on any item found not to have been in accordance with the contract specifications.

SAVING CLAUSE

54. The successful bidder shall not be held responsible for any losses resulting if the fulfillment of the terms of the contract shall be delayed or prevented by wars, acts of public enemies, strikes, fire, floods, acts of God, or for any other acts not within the control of the successful bidder and which by the exercise of reasonable diligence he is unable to prevent.

BIDDING DATES

55. If for any reason the Purchasing Office is closed on the designated day for the bid opening, the opening will take place on the first subsequent day the Purchasing Office is officially opened.

TOXIC SUBSTANCES

56. Each vendor furnishing a toxic substance, as defined by section 875 of New York State Labor Law, to the School district, shall provide not less than two (2) copies of a MATERIAL SAFETY DATA SHEET. The sheet shall include the information outline in Section 876 of New York State Labor Law (a copy of Section 876; 876 maybe obtained by calling the School district's Puchasing Office) for each such substance.

BUYING AGAINST CONTRACT

57. If the contractor fails to make proper delivery within the delivery is rejected by the School district, the School district may obtain such commodities or any part thereof from other sources in the open market or on contract. Should the new price be greater than the contract price the difference, if any, will be charged against the contractor. This will also apply to reletting and liquidation damages. Should the new price be less, the contractor shall have no claim to the difference.

NOTE: A NONCOLLUSIVE BIDDING CERTIFICATION MUST BE SUBMITTED WITH EACH BID. THE ENCLOSED FORM "BID PROPROSAL CERTIFICATIONS", MEETS THIS REQUIREMENT.

SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT

60 WESTON STREET, HUNTINGTON STATION, NY 11746

BID PROPOSAL CERTIFICATIONS

Firm Name _____

Business Address _____

Telephone Number _____ Date of Bid _____

I. General Bid Certification

The bidder certifies that he will furnish, at the prices herein quoted, the materials, equipment, and/or services as proposed on this bid.

II. Non-Collusive Bidding Certification

By submission of this bid proposal, the bidder certifies that he is complying with Section 103-d of the General Municipal Law as follows:

Statement of non-collusion in bids and proposals to political subdivision of the state. Every bid or proposal here-after made to a political subdivision of the state or any public department, agency or official thereof where competitive bidding is required by statute, rule, regulation, or local law, for work or services performed or to be performed or goods sold or to be sold, shall contain the following statement subscribed by the bidder and affirmed by such bidder as true under the penalties of perjury:
Non-collusive bidding certification.

A. By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of its knowledge and belief:

(1) The prices in this bid have been arrived at independently without collusion, consultation, communication or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor.

(2) Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly, to any other bidder or to any competitor; and

(3) No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not submit a bid for the purpose of restricting competition.

B. A bid shall not be considered for award nor shall any award be made where A. (1) (2) and (3) above have not been complied with; provided, however, that if in any case the bidder shall so state and shall furnish with the bid a signed statement which set forth in detail the reasons therefore. Where A. (1) (2) and (3) above have not been complied with, the bid shall not be considered for award nor shall any award by made unless the head of the purchasing unit of the political subdivision, public department, agency or official thereof to which the bid is made, or his designee, determines that such disclosure was not made for the purpose of restricting competition.

(1) The fact that a bidder (a) has published price lists, rates, or tariffs covering items being procured, (b) has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or (c) has sold the same items to other customers at the same prices being bid, does not constitute, without more, a disclosure within the meaning subparagraph one (a).

(2) Any bid hereafter made to any subdivision of the state or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods sold or to be sold, where competitive bidding is required by stature, rule, regulation, or local law, and where such bid contains the certification referred to in subdivision one of the section, shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation.

Authorized Signature _____

Title _____

SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT

60 WESTON STREET, HUNTINGTON STATION, NY 11746

Firm Name: _____

Business Address : _____

Telephone Number: _____ Date of Bid: _____

IRAN DIVESTMENT ACT CERTIFICATION OF COMPLIANCE WITH THE IRAN DIVESTMENT ACT

As a result of the Iran Divestment Act of 2012 (the "Act"), Chapter 1 of the 2012 Laws of New York, a new provision has been added to State Finance Law (SFL) § 165-a and New York General Municipal Law § 103-g, both effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (OGS) will be developing a list of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law) (the "Prohibited Entities List"). Pursuant to SFL § 165-a(3)(b), the initial list is expected to be issued no later than 120 days after the Act's effective date at which time it will be posted on the OGS website.

By submitting a proposal in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, each Proposer/Contractor, any person signing on behalf of any Proposer/Contractor and any assignee or subcontractor and, in the case of a joint proposal, each party thereto, certifies, under penalty of perjury, that once the Prohibited Entities List is posted on the OGS website, that to the best of its knowledge and belief, that each Proposer/Contractor and any subcontractor or assignee is not identified on the Prohibited Entities List created pursuant to SFL § 165-a(3)(b).

Additionally, Proposer/Contractor is advised that once the Prohibited Entities List is posted on the OGS Website, any Proposer/Contractor seeking to renew or extend a Contract or assume the responsibility of a Contract awarded in response to this solicitation must certify at the time the Contract is renewed, extended or assigned that it is not included on the Prohibited Entities List.

During the term of the Contract, should the School District receive information that a Proposer/Contractor is in violation of the above-referenced certification, the School District will offer the person or entity an opportunity to respond. If the person or entity fails to demonstrate that he/she/it has ceased engagement in the investment which is in violation of the Act within 90 days after the determination of such violation, then the School District shall take such action as may be appropriate including, but not limited to, imposing sanctions, seeking compliance, recovering damages or declaring the Proposer/Contractor in default. The School District reserves the right to reject any proposal or request for assignment for a Proposer/Contractor that appears on the Prohibited Entities List prior to the award of a contract and to pursue a responsibility review with respect to any Proposer/Contractor that is awarded a contract and subsequently appears on the Prohibited Entities List.

Certified under penalty of perjury:

Date: _____

Signature: _____

Print Name: _____

Title: _____

DECLARATION OF BIDDER'S INABILITY TO PROVIDE CERTIFICATION OF COMPLIANCE WITH THE IRAN DIVESTMENT ACT

Bidders shall complete this form if they cannot certify that the Bidder/Contractor or any proposed Subcontractor is not identified on the Prohibited Entities List. The District reserves the right to undertake any investigation into the information provided herein or to request additional information from the bidder.

Name of the Bidder: _____

Address of the Bidder: _____

Has bidder been involved in investment activities in Iran? _____
Describe the type of activities including but not limited to the amounts and the nature of the investments (e.g. banking, energy, real estate) _____

_____

_____

If so, when did the first investment activity occur? _____

Have the investments ended? _____

If so, what was the date of the last investment activity? _____

Has the bidder adopted, publicized, or implemented a formal plan to cease the investment activities in Iran and to refrain from engaging in any new investments in Iran? _____

If so, provide the date of the adoption of the plan by the bidder and proof of the adopted resolution, if any and a copy of the formal plan: _____

In detail, state the reasons why the bidder cannot provide the Certification of Compliance with the Iran Divestment Act below (additional pages may be attached):

_____,

_____

_____

_____

_____

I, _____ being duly sworn, deposes and says that he/she is the

_____ of the _____ Corporation and the foregoing are true and accurate.

_____

Signature

Sworn to me this

_____ day of _____, 20__

_____

Printed Name

Notary Public: _____

KT20

SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT

60 WESTON STREET, HUNTINGTON STATION, NY 11746

Certification of Sexual Harassment Prevention in the Workplace Policy and Annual Sexual Harassment Prevention Training of All Employees Pursuant to NYS Finance Law § 139-1

Firm Name: _____

Business Address : _____

Telephone Number: _____ Date of Bid: _____

By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that the bidder has implemented a written policy addressing sexual harassment prevention in the workplace and provides annual sexual harassment prevention training to all of its employees. Such policy shall, at a minimum, meet the requirements of Section Two Hundred One-g of the Labor Law (NY Labor Law §201-g).

A bid shall not be considered for award nor shall any award be made to a bidder who has not complied with the certification requirements of NYS Finance Law § 139-1(l); provided, however, that if the bidder cannot make the foregoing certification, such bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefor.

Any bid hereafter made by a corporate bidder for work or services performed or to be performed or goods sold or to be sold, where such bid contains the statement required by NYS Finance Law § 139-1(l), shall be deemed to have been authorized by the board of directors of such bidder, and such authorization shall be deemed to include the signing and submission of such bid and the inclusion therein of such statement as the act and deed of the corporation.

Certified under penalty of perjury:

Signature: _____

Print Name: _____

Title: _____

SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT

60 Weston Street
Huntington Station, NY 11746

VENDOR DISCLOSURE CERTIFICATION

Vendor must complete either section A or B below

A. This is to certify that the principal members of the company listed below are not related to any Board members, officers or employees of South Huntington UFSD.

_____ _____ _____
Signature Date Company Name

_____
Print Name

B. This is to certify that the following South Huntington UFSD Board members, officers or employees are related to principal members of the company listed below.

Name	Relationship	Name of South Huntington Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____
Signature Date Company Name

_____
Print Name

SOUTH HUNTINGTON UNION FREE SCHOOL DISTRICT

60 WESTON STREET
HUNTINGTON STATION, NEW YORK 11746

NON-PROPOSER RESPONSE

RFP FOR STUDENT ACCIDENT INSURANCE

The South Huntington UFSD is interested in the reasons why Proposers fail to submit proposals. Please indicate your reason(s) by checking all appropriate item(s) below and returning this form to the above address.

___ Could not meet Scope of Services

___ Insurance requirements too restricting

___ Scope of Services not clearly understood or applicable (too vague, too rigid, etc.)

___ Project not suited to firm

___ Quantities/project too small

___ Insufficient time allowed for preparation of bid/proposal

___ Other reasons – please state and define: _____

_____

_____

_____

_____

_____

Company Name: _____

Contact Person: _____

Company Address: _____

Telephone: _____