Student Accident and Health Insurance Program

Designed for Students of

August 1, 2012 to August 1, 2013

POLICY NUMBER: 2012H4A07

Please keep this Certificate for future reference.

12-H4A07 (Bro.)
This student health insurance coverage is compliant with the HHS ruling of March 16, 2012 that pertains to student health insurance. However, it may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits pertaining to types of health insurance other than Student Health Insurance. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Your student health insurance coverage has an annual limit of $100,000 on all covered benefits. If you have any questions or concerns about this notice, contact the Underwriting Company stated in this brochure. You may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s plan for more information.
Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, Stork Insurance Agency at 315-536-2363, or the Administrative Agency at Haylor, Freyer & Coon, Inc. at 1-800-289-1501.

**COVERAGE**

1. Accident and Sickness coverage begins on August 1, 2012, or the date of enrollment in the plan, whichever is later and ends August 1, 2013.
2. Benefits are payable during the term of the policy from the date of the accident or first treatment of sickness. To be eligible for benefits, the insured must incur covered medical expense within 60 days from the date of the accident or the commencement of sickness.
3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the expiration date of the policy. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.

**Limited benefits health insurance.** The insurance evidenced by this Certificate provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical, major medical or Medicare supplement insurance as defined by the New York State Insurance Department.

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**Section 1 — Definitions**

The terms listed below, if used in this Certificate, have the meanings stated.

**Accident** means bodily injury caused by specific accidental contact with another body or object during the Insured Person’s term of insurance, and which is unrelated to any pathological, functional, or structural disorder or injury, and which first requires medical treatment during the Insured Person’s term of insurance.

**Ambulance Service** means ground transportation to the nearest hospital by a professional ambulance service.

**Anesthetist** means any physician or nurse who is duly qualified to administer anesthesia during a surgical procedure and who is not an employee of the hospital or other facility where the surgery is performed.

**Consultant** means any physician whose practice is limited to a recognized medical specialty other than family practice.

**Covered Expense** means those expenses incurred for the treatment of an accident and/or sickness that: (1) are incurred on the approval of a Physician; (2) do not
Section II — Basic Medical Expense Benefits for Accident & Sickness

When you suffer a Loss from Accident or Sickness, we will pay 80% of the Covered Expense incurred during the term of the Policy, up to an aggregate maximum benefit of $100,000 after a $100 deductible. Benefits per accident or sickness are allocated as follows:

Hospital Room and Board Expense: When you require Hospital Confinement, we will pay the Covered Expense for hospital room and board up to the semi-private rate.

Miscellaneous Hospital Expense: We will pay Covered Expense incurred by you during a Hospital Confinement or as an Outpatient for day surgery. We will pay for anesthesia, operating room, laboratory tests, x-rays, use of oxygen, drugs, medicines, dressings, and other necessary non-room and board hospital expenses.

Surgical Expense: When you require surgery, we will pay the reasonable and customary surgical fee based on the current nationally recognized survey of prevailing fees.

If the surgery requires the services of an anesthetist, who is not employed or retained by the hospital in which the operation is performed, we will pay the Loss incurred.

Assistant Surgeon Expense: We will pay for the services of an assistant surgeon.

In-Hospital Physician’s Fees Expense: When your Sickness requires the services of a Physician, we will pay the Covered Expense for such services.

Out-of-Hospital Physician Fees Expense: When your Sickness requires the services of a physician while not confined to a hospital, we will pay the Covered Expense.

Outpatient Diagnostic X-ray and Laboratory Expense: When your Sickness requires x-ray examinations, laboratory tests, emergency room, and the hospital physician charges, we will pay the Covered Expense.

Maternity Expense Benefit: Expenses for pregnancy are covered to the same extent that coverage is provided for any other sickness.

Prescription Drugs Expense: We will pay the Covered Expense for drugs and medicines prescribed by the attending physician.

Preadmission Testing: We will pay the Covered Expense made by a Hospital for the use of its outpatient facilities for tests that are completed in preparation for a previously scheduled admission for inpatient surgery.

Emergency Medical Expense: We will pay the Covered Expense for emergency medical services pro-
vided by a Hospital. Such emergency services must be provided within 24 hours after the appearance of symptoms of a Sickness or within 72 hours after an Accident.

**Hospital Outpatient Expense:** We will pay the Covered Expense for the use of Hospital outpatient facilities or emergency room, including X-ray and laboratory services. The use of such services must be prescribed by the attending Physician.

**Outpatient Treatment for Mental and Emotional Disorders:** (See Mandated Benefits, page 14).

**Ambulance Expense:** We will pay the Covered Expense for ambulance service.

**Preventive and Wellness Services:** We will pay the Covered Expense for Preventive and Wellness Services at 100% of Usual and Customary, not subject to any copay, coinsurance or deductible.

**Section III — Additional Benefits**

The following mandated benefits will be paid the same as for any other covered sickness, unless stated otherwise. All mandated benefits are subject to the terms and conditions generally applicable to other benefits provided under the policy. If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

**Maternity Care** - We will pay benefits for maternity care, including Hospital, surgical or medical care, to the same extent that coverage is provided for illness or disease is covered under the policy. Such care, other than coverage for Complications of Pregnancy, will include: (1) Not less than two payments, at reasonable intervals and for services rendered, for prenatal care, and a separate payment for delivery and postnatal care; (2) Inpatient Hospital coverage for mother and newborn for at least 48 hours after childbirth for any delivery other than a caesarean section, and for at least 96 hours after a caesarean section. Maternity care coverage will include the services of a licensed midwife who is affiliated or practicing in conjunction with a facility licensed according to public health law. We will NOT pay for duplicative routine services actually provided by both a licensed midwife and a Physician; (3) Parent education, assistance and training in breast or bottle feeding; and (4) The performance of any necessary maternal and newborn clinical assessments; (5) If the mother should elect to be discharged earlier than the time frame in item 1 of this provision, the inpatient benefit will include at least one home care visit that will be in addition to any home health care coverage available under the Policy. Such a visit may be requested at any time within 48 or 96 hours of the time of delivery and will be delivered within 24 hours of either the mother discharge or of the time of the mother’s request, whichever is later. This visit will not be subject to deductibles, coinsurance or copayments.

**Home Health Care** - If, as the result of a covered Injury or Sickness, an Insured Person requires any of the home health care services, as defined, We will pay the reasonable Covered Expense incurred for such services. Covered Expense for such services must be incurred within 156 weeks from the date of the Injury or the start of a covered Sickness. The maximum number of home health care visits is limited to 40 in any period of 12 consecutive months. The amount of this benefit is 75% of the reasonable Covered Expense for the above services made by a Home Health Care Agency, minus a deductible of $50 per year.

This benefit does not cover: (1) services furnished outside the State of New York unless they are rendered by an entity licensed to provide Home Health Care in the state where the services were rendered; (2) persons who are not residents of the State of New York; (3) persons who are eligible for Medicare due to age; (4) services which are not part of a Home Health Care plan; (5) services provided by an immediate family member of an Insured Person or a member of an Insured Person’s household; (6) custodial care or transportation; or (7) any period during which an Insured Person was not under the care of a Physician.

**Diabetes Equipment, Supplies and Service** - When Sickness coverage is provided under the Policy, after a $25 deductible per school year, we will pay a benefit for Covered Expense incurred for the following equipment, supplies and services in the treatment of diabetes. Equipment and supplies that may be medically necessary for the treatment of diabetes include, but are not limited to the following: a.) Lancets and automatic lancing devices; b.) Glucose test strips; c.) Blood glucose monitors; d.) Blood glucose monitors for visually impaired; e.) Control solutions used in blood glucose monitors; f.) Diabetes data management systems for management of blood glucose; g.) Urine testing products for glucose and ketones h.) Oral anti-diabetic agents used to reduce blood sugar levels; i.) Alcohol swabs; j.) Syringes; k.) Injection aids including insulin drawing up devices for the visually impaired; l.) Cartridges for the visually impaired; m.) Disposable insulin cartridges and pen cartridges; n.) All insulin preparations; o.) Insulin pumps and equipment for the use of the pump including batteries; p.) Insulin infusion devices; q.) Oral agents for treating hypoglycemia such as glucose tablets and gels; r.) Glucagon for injection to increase blood glucose concentration; s.) Other diabetes equipment and related supplies that are medically necessary for the treatment of diabetes.
We will also pay Usual and Customary Covered Expense for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets.

This benefit will be limited to visits medically necessary upon the diagnosis of diabetes, where a Physician diagnoses a significant change in the Insured Person’s symptoms or conditions that necessitate changes in an Insured Person’s self-management or where reeducation or refresher education is necessary. Coverage also includes home visits when medically necessary.

Such education may be provided by: a.) the Physician or other licensed health care provider legally authorized to prescribe under Title 8 of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment; or b.) a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral of a Physician or other licensed health care provider.

Education provided by the certified diabetes nurse educator, certified nutritionist or registered dietitian is limited to group settings wherever practicable.

**Inpatient Treatment for Alcoholism and Substance Abuse** - We will pay the Covered Expense incurred for the diagnosis and treatment of alcoholism or alcohol abuse and substance abuse or substance dependency. We will pay such benefit as follows: a.) Detoxification benefits - treatment in an inpatient facility for up to seven (7) days in any calendar year; and b.) Rehabilitation services - treatment in an inpatient facility for up to 30 days in any calendar year.

Treatment and services must be provided by facilities in New York State that are certified by the Division of Alcoholism and Alcohol Abuse or with the Division of Substance Abuse Services and, in other states, to those which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism or substance abuse treatment programs.

**Outpatient Treatment of Alcoholism and Substance Abuse** - If an Insured Person incurs Covered Expense for the diagnosis and treatment of alcoholism, alcohol abuse or substance abuse, We will pay the reasonable Covered Expense incurred for such treatment. The maximum number of outpatient visits is limited to 60 in any period of 12 consecutive months. Twenty of these visits may be used as family member visits. Only one visit per day is covered.

“Visit” means diagnostic medical or therapeutic services or comprehensive, day or clinic visits. For family members, visits include counseling and education. Socialization visits are not covered.

Treatment and services must be provided: (1) in New York State, by facilities that are certified by the Division of Alcoholism and Alcohol Abuse or the Division of Substance Abuse Services; or (2) in other states, by facilities that are accredited by the joint commission on accreditation of Hospitals as alcoholism or substance abuse treatment programs.

**Second Medical Opinion** - We will pay the Covered Expense incurred for a second medical opinion by an appropriate specialist, including but not limited to, a specialist affiliated with a specialty care center for the treatment of cancer in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

**Breast Cancer Benefit** - (1) Hospitalization benefits will be payable for such period of time as determined by the attending Physician in consultation with the patient to be medically appropriate when the patient is undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the Policy. Such treatment will be subject to any annual deductible and coinsurance amounts shown in the Schedule of Benefits; (2) We will pay the Covered Expense incurred for breast reconstructive surgery following a covered mastectomy as follows: a.) All stages of reconstruction of the breast on which the mastectomy has been performed; and b.) Surgery and reconstruction of the other breast to produce a symmetrical appearance. Such reconstructive surgery will be in the manner determined by the attending Physician in consultation with the patient to be appropriate; (3) We will pay the Covered Expense incurred for prostheses and the treatment of physical complications for all stages of a mastectomy, including lymphedemas.

**Enteral Formula Benefit** - When an issued policy covers prescription drugs, as part of that benefit, We will pay the Covered Expense incurred for the cost of enteral formulas for home use when prescribed by a Physician or other licensed health care provider. Any prescription from the Physician or licensed health care provider must state the use of such formulas is clearly Medically Necessary and has been proven effective as a disease-specific treatment for an Insured Person who is or who will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death.

Enteral formulas which are Medically Necessary and taken under written prescription from a Physician for the treatment of specific diseases will be distinguished from...
nutritional supplements taken electively. Specific diseases for which enteral formulas have been proven effective include, but are not limited to, inherited diseases of amino acid or organic acid metabolism; Crohn’s Disease; gastroesophageal reflux with failure to thrive; disorders of the gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies which, if left untreated, will cause malnourishment, chronic physical disability, mental retardation and death.

Coverage for certain inherited diseases of amino acid and organic acid metabolism will include modified solid food products that are low protein or which contain modified protein which are Medically Necessary. Such coverage for any continuous 12 month period for any Insured Person will not exceed $2,500.00.

Chiropractic Care Benefit - We will pay the Covered Expense incurred for chiropractic care, performed by a doctor of chiropractic, to the same extent as would be payable for Physician’s services in a Physician’s office. Chiropractic care must be in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose 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.

Experimental or Investigational Treatment or Clinical Trials Expense - The Company will pay the Covered Expense incurred for patient care service furnished in connection with experimental or investigational treatments or as part of a clinical trial. Coverage for the services required under this benefit are provided subject to the terms and conditions generally applicable to other benefits provided under the Policy.

Cancer Screening Tests - The Company will pay the Covered Expense incurred for the following cancer screening tests. (1) Mammography screening for occult breast cancer as follows: (a) At any age upon the recommendation of a Physician, a mammogram at any age for Insured Persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer; (b) A single baseline mammogram for covered persons age 35 to 39 inclusive; (c) An annual mammogram for covered persons age 40 and older. As used in this provision, mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose of less than 0.5 rem per view per breast. (2) Annual cervical cytology screening (PAP tests) for cervical cancer and its precursor states for women age 18 years and older as recommended by a Physician. As used in this provision, cervical cytology screening will include an annual pelvic examination, collection and preparation of a Pap smear and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear; and (3) Prostate cancer screening, as follows: (a) Standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and (b) An annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer factors.

Prehospital Emergency Medical Services - The Company will pay the Covered Expense incurred for prehospital emergency medical services for the treatment of an emergency condition when such services are provided by a certified ambulance service.

Cancer Prescription Drug Expenses - When the policy includes a benefit for prescription drugs, this benefit will include the Covered Expense incurred for prescription drugs used for the treatment of cancer. This includes coverage of drugs that have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in one of the following established reference compendia: (1) The American Medical Association Drug Evaluations; (2) The American Hospital Formulary Service Drug Information; or (3) The United States Pharmacopeia Drug Information; or (4) Recommended by review articles or editorial comment in a major peer reviewed professional journal.

Coverage will not be provided for any experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

Mental, Nervous or Emotional Disorders - We will pay benefits for the eligible expenses incurred for thirty (30) days of inpatient treatment and twenty (20) outpatient visits. For the purposes of this benefit two (2) partial hospitalization visits will be equal to one (1) inpatient day. Coverage will include benefits for Biologically Based Mental Illness and Children with Serious Emotional Disturbances and will be covered to the same extent that coverage is provided for any other sickness.

For the purpose of this benefit, Biologically Based Mental Illness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syn-
drome or pattern that substantially limits the functioning of the person with the illness. Biologically Based Mental Illness includes: (1) Schizophrenia/psychotic disorders; (2) Major depression; (3) Bipolar disorder; (4) Delusional disorders; (5) Panic disorder; (6) Obsessive compulsive disorders; (7) Anorexia; and (8) Bulimia.

For the purpose of this benefit, Children with Serious Emotional Disturbances means those persons under the age of eighteen years who have a diagnosis of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders and one or more of the following: (1) Serious suicidal symptoms or other life-threatening self-destructive behaviors; (2) Significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); (3) Behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or (4) Behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

For the purpose of this benefit, Mental, Nervous or Emotional Disorders means medically necessary care rendered by an eligible practitioner or approved facility that is directed predominately at treatable behavioral manifestations of a condition that the attending physician determines (a) is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and (b) substantially or materially impairs a person's ability to function in one or more major life activities; and (c) has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Section IV — Exclusions

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of that Act.

The Policy does not cover any loss contributed to or resulting from:
- the practice or play of interscholastic sports;
- suicide or attempted suicide, or any self-inflicted injury;
- mental or emotional disorders; alcoholism or drug addiction (except as may be specifically provided by rider to the Policy);
- war or any act of war, whether or not declared;
- participation in a felony, riot or insurrection;
- air travel or the use of any device or equipment for aerial navigation, except as a farepaying passenger on a regularly-scheduled commercial airline; or
- service in any armed forces, military reserves or militia.

Nor does the Policy provide benefits for:
- eyeglasses, contact lenses, hearing aids, or examinations therefor;
- expenses for which benefits are paid under any Workers’ Compensation law or similar law or under any mandatory no-fault automobile insurance;
- cosmetic surgery, except reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- treatment provided in a government Hospital, unless there is a legal obligation to pay for such service in the absence of insurance;
- treatment or service by any person or facility employed or retained by the school;
- treatment or service provided by a member of the Insured Person's family or household, for which no charge is normally made;
- voluntary or elective abortion, except as may be specifically provided by the Policy;
- dental care or treatment, except for injury to sound natural teeth caused by an accident; and
- preventive medicines, serums or vaccines, except as may be specifically provided by the policy.

Section V — General Policy Provisions

Notice of Claim: Written notice of claim must be given to the COMPANY within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the COMPANY at its Home Office in Utica, New York, or to any authorized agent of the COMPANY, with information sufficient to identify the Insured Student shall be deemed notice to the COMPANY.

Claim Forms: The COMPANY, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made.

Proof of Loss: Written Proof of Loss must be furnished to the COMPANY at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.
Time of Payment of Claims: Indemnities payable under the Policy will be paid immediately upon receipt of due written proof of such loss.

Payment of Claims: Indemnity (if any) for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity, shall be payable to the estate of the Insured person. Any other accrued indemnities unpaid at the Insured Person’s death may, at the option of the COMPANY, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured Person.

If any indemnity of the Policy shall be payable to the estate of an Insured Person or to an Insured Person who is a minor or otherwise not competent to give a valid release, the COMPANY may pay such indemnity, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage of the Insured Person who is deemed by the COMPANY to be equitably entitled thereto. Any payment made by the COMPANY in good faith pursuant to this provision shall fully discharge the COMPANY to the extent of such payment.

Subject to any written direction of the Insured Person in an application or otherwise, all or a portion of any indemnities provided by the Policy on account of hospital, nursing, medical or surgical service may, at the COMPANY’s option and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Physical Examination and Autopsy: The COMPANY at its own expense shall have the right and opportunity to examine the person of any individual whose injury is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder 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 shall be brought to recover on the Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Part VI — Additional Provisions

The COMPANY does not assume any responsibility for the validity of an assignment.

The Insured Person shall have free choice of a legally qualified physician with the understanding that the physician-patient relationship shall be maintained.

The acknowledgement by the COMPANY of the receipt of notice given under the Policy, or the furnishing of forms for filing proofs of loss, or the acceptance of such proof, or the investigation of any claim hereunder shall not operate as a waiver of any rights of the COMPANY in defense of any claim arising under the Policy.

CLAIM PROCEDURE

In the event of Accident or Sickness the student should:

1. If at the College, report immediately to Keuka Health Services so that proper treatment can be prescribed or approved.
2. If away from the College, consult a doctor and follow his or her advice. Notify Keuka Health Services within (30) days after the date of the covered accident or commencement of the covered illness or as soon thereafter as is reasonably possible.
3. Secure a claim form from Keuka Health Services, the Student Accounts Office, or the Administrator’s website: www.commercialtravelers.com/college.html.
4. Complete the form.
5. Submit the claim form, complete with bills and receipts, to the Claims Administrator: Commercial Travelers Mutual Insurance Company, 70 Genesee Street, Utica, NY 13502.
6. Submit only one claim form for each accident or illness.

Note: Notification of illness or accident must be furnished within 30 days after the date of accident or commencement of sickness. Bills for which benefits are to be paid must be submitted within 90 days.

HOW TO FILE AN APPEAL

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an insured student who disagrees with how a claim was processed may appeal that decision. The student must request an appeal in writing within 60 days of the date appearing on the EOB. The appeal request must include why they disagree with the way the claim was processed. The request must include any additional information they feel supports their request for appeal, e.g. medical records, physician records, etc. Please submit all appeal requests to the Claims Administrator at the address on back panel.
ENDORSEMENT

The Mandated Benefits provision of the Blanket Student Accident and Health Insurance Policy/Certificate to which this Endorsement is attached is amended to include the following.

Contraceptive Drugs and Devices Expense
- When the Policy to which this endorsement is attached includes coverage for prescription drugs, such coverage will also include the expenses incurred for prescription contraceptive drugs and devices. All contraceptive drugs and devices must be approved for use by the United States Food and Drug Administration (FDA) or the generic equivalents approved as substitutes by the FDA under the prescription of a health care provider who is legally authorized to prescribe same. Any benefits provided under this Endorsement are [not] subject to any annual deductibles and coinsurance provisions of the policy as are consistent with those established for other prescription drugs and devices covered under the policy. The above benefit is mandated for all policies issued with a prescription drug benefit.

This Endorsement takes effect with and expires with the Policy/Certificate to which it is attached. It is subject to all of the terms, conditions, limitations, and exclusions of the Policy/Certificate.

IN WITNESS WHEREOF, Commercial Travelers Mutual Insurance Company has caused this Endorsement to be signed by its President and Secretary.

Mathew J. Drew
Secretary

Mark E. Henderson
President

CT-235 END03P (CD&D)
The Plan Is Underwritten and Claims Administered by:

Commercial Travelers Mutual Insurance Company
70 Genesee Street
Utica, NY 13502
(800) 756-3702

as policy form # SH-1-88

For a copy of the Company’s privacy notice you may:

go to
www.commercialtravelers.com/privacy.html

or

Request one from the Health office at your school

or

Request one from:
Commercial Travelers Mutual Insurance Company
c/o Privacy Officer
70 Genesee Street • Utica, NY 13502

(Please indicate the school you attend with your written request.)

Note: The time you were covered under this plan may count as creditable coverage under State and Federal Law if you leave this plan and go to an employer’s plan within 63 days thereafter. You are eligible to receive a certification from the Company regarding the periods you were covered. Please contact the Local Administrator listed in this brochure when you need such certification.

Representations of this plan must be approved by the Company.

IMPORTANT

THIS CERTIFICATE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE AS DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE AT THE COLLEGE.