

2008–2009 Student Accident and Health Insurance Program

Designed especially for:



Garden City, New York 11530

Policy Number: 2008M9A00

Go to the Adelphi Health Service Center First

PLEASE NOTE: Students and their eligible dependents with other medical insurance are also eligible for the Optional Insurance and should consider this opportunity to obtain this low cost coverage. It is an ideal supplement and will help protect against medical expense not fully covered by other insurance.

**Please keep this Certificate
for future reference.**

08-M9A00 (Bro.)

All registered students, while enrolled at the University, are automatically provided the Basic Accident Insurance Benefits as described under Section I of this brochure. Coverage begins at 12:01 A.M. on August 15, 2008 and ends at 12:01 A.M. on August 15, 2009.

Students living in the University residence halls and international students not showing proof of other coverage are automatically provided the **Sickness Medical Expense Benefit and Supplemental Medical Expense Benefit as described in Sections II and III**. Those who have comparable coverage under a family policy may waive such coverage by completing an Insurance Waiver Form. Waiver Forms must be returned to the Adelphi Health Service Center by **October 5, 2008** in order to have the charge removed from your bill.

Coverage under the **Sickness Medical Expense Benefit and Supplemental Medical Expense Benefits (Sections II and III)** becomes effective at 12:01 A.M. on August 15, 2008 (or postmark date of premium payment, whichever is later) and ends at 12:01 A.M. on August 15, 2009. Those students covered under **Sections II and III** also remain covered under **Section I** until 12:01 A.M. on August 15, 2009, regardless as to whether they return for the spring or summer semester.

The insurance coverage under the **Enhanced Supplemental Accident and Sickness Medical Expense Benefits (Section IV)** becomes effective at 12:01 A.M. on August 15, 2008 and continues until 12:01 A.M. on August 15, 2009. Only those students enrolled for **Sickness Medical Expense Benefits and Supplemental Medical Expense Benefits (Sections II and III)** may enroll for the **Enhanced Supplemental Accident and Sickness Medical Expense Benefits (Section IV)**. This optional coverage begins on the date **Sections II and III** begin, or date premium is paid, whichever is later, and continues until 12:01 A.M. on August 15, 2009. The general terms and conditions of this Plan apply to this optional coverage.

Termination Date of Coverage: Coverage under the Policy with respect to the Insured student will terminate on the earlier of the following: (1) the last date of the period for which premium has been paid;

(2) the date the Insured student ceases to be eligible for the insurance provided; (3) the date the policy terminates.

ELIGIBILITY

Enrollment is available to all registered students. To enroll, complete an Enrollment Form and return it with premium payment to CT Agency, 70 Genesee St., Utica, NY 13502. **The last date for open enrollment for fall semester is October 5, 2008 and March 5, 2009 for the spring semester.**

An insurance ID card will be issued to Students purchasing the **Sickness and Supplement Medical Expense Benefits (Sections II & III)**.

DEPENDENT COVERAGE

Students enrolling in the optional plans may obtain coverage for a spouse and/or dependent children under the age of 19. Dependent Enrollment Forms are available at the Adelphi Health Service Center.

Dependents must enroll for the same term of coverage for which the Insured Student enrolls. Dependent coverage (except for newborn infants) must be applied for at the same time the student enrolls.

CERTIFICATE OF STUDENT BLANKET HEALTH INSURANCE

issued by
**SECURITY MUTUAL LIFE INSURANCE
COMPANY OF NEW YORK
Binghamton, NY**

(Herein called "the COMPANY")

The COMPANY hereby certifies that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form SML-100 ("the Policy").

Limited Benefits Health Insurance

The insurance evidenced by this brochure provides limited benefits health insurance only.

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Part 1 — Definitions

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

Accident means bodily injury directly 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.

Note: This Plan is intended to supplement the services provided by the Student Health Center.

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

Covered Expense means the fees and prices regularly and customarily charged for medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographic area concerned. Expense is considered to be incurred on the date the service or supply is rendered or obtained.

Hospital means an institution which is licensed as a hospital by the state in which it is located and: (1) has permanent full-time facilities for bed care of five or more resident patients; (2) has a physician in regular attendance or on call at all times; (3) has 24 hours a day service by registered graduate nurses; (4) primarily provides diagnostic and therapeutic facilities for the medical and surgical care of patients; and (5) is not a rest home, nursing home, convalescent home, hospice, or place for the aged or for alcoholics or for drug addicts, or an institution primarily for the treatment of mental disorders.

Hospital Confined or **Hospital Confinement** means a stay of at least 18 hours as a resident patient in a hospital.

Insured Person means an eligible student who is enrolled for coverage and for whom the required premium has been paid.

Mental or Emotional Disorder means any mental, emotional or behavioral disorder which is not primarily caused by organic disease.

Physician means a person licensed as such by the state in which he or she practices, other than a member of the Insured Person's immediate family. A dentist shall be considered a physician when providing treatment for which benefits are payable under the Policy.

School means the college or university to which the Policy is issued and which the insured student attends.

Sickness means illness or disease first diagnosed or treated during the Insured Person's term of insurance. The term "sickness" includes pregnancy which commences during the Insured Person's term of insurance.

Term of Insurance means the period of coverage for which premium for the Insured Person has been paid.

Part 2 — Mandatory Insurance: (Student's Only) Section I

SECTION I BASIC ACCIDENT BENEFITS

We will pay benefits for the following covered expenses incurred as the result of a covered accident within 52 weeks after the date of accident. Benefits may not exceed the Maximum Benefit of \$2,000 per accident. Treatment must begin within 60 days of a covered Accident. Covered Expenses include the following: (a) treatment by a physician; (b) Hospital Confinement; (c) services of a licensed practical nurse or RN; (d) x-ray service; (e) use of operating room, anesthesia, laboratory service; (f) use of an ambulance; (g) use of an Ambulatory Surgical Center or Ambulatory Medical Center; (h) if ordered by a physician, prescription medicines, drugs, or any other therapeutic services or supplies; or (i) Home Health Care. This benefit includes coverage for treatment of injury to natural teeth.

ACCIDENTAL DEATH AND DISMEMBERMENT

If the Insured Person sustains any of the following losses as the result of a covered Accident, within 52 weeks after the date of accident, the COMPANY will pay the amount shown.

For Loss of	Amount
Life	\$.5,000
Both hands or both feet or sight of both eyes	\$.5,000
One hand and one foot	\$.5,000
One hand and sight of one eye	\$.5,000
One foot and sight of one eye	\$.5,000
One hand or one foot or sight of one eye . .	\$.2,500

Loss of hand or foot means complete severance through or above the wrist or ankle joint. Loss of an eye means the total permanent loss of sight in the eye.

Principal Sum: \$5,000. The Principal Sum is the largest amount payable under this benefit for all losses resulting from any one Accident.

Part 3 — Optional Insurance: Section II, III and IV

SECTION II

BASIC SICKNESS BENEFITS

When you suffer a Loss from Sickness, we will pay for such expenses, subject to all the terms of the Policy, up to the limits shown and to the extent herein provided, subject to the following: (1) no payment will be made for any expense incurred more than 52 weeks after the date of first treatment by a physician, and (2) the aggregate amount of all benefits shall not exceed \$2,500 as the result of any one sickness. Benefits are allocated as follows:

Hospital Room and Board Expense: When your Sickness requires Hospital Confinement, we will pay the hospital room and board Expense up to the semi-private rate, up to \$250 per day.

Miscellaneous Hospital Expense: We will pay covered expenses incurred by you during a Hospital Confinement or as an Outpatient for day surgery, up to a maximum of \$1,000. We will pay for anesthesia, operating room, laboratory tests, x-rays, oxygen tent, drugs, medicines, dressings, and other necessary non-room and board hospital expenses.

Surgical Expense: When your Sickness requires surgery, we will pay the Usual and Customary expense up to a Maximum Per Operation of \$2,000.

Ambulance Expense: When your Sickness requires the use of an ambulance, we will pay the covered expense up to \$100 for transportation to or from the hospital.

In-Hospital Physician's Fees Expense: When your Sickness requires the services of a Physician, we will pay the covered expense for such services limited to one visit per day, up to \$64 per visit.

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 up to \$5 per visit, limited to one visit per day. If treatment is rendered by a physician referred by Adelphi Health Service Center, we will pay the eligible charges, not to exceed \$125 per visit, limited to one visit per day on an outpatient basis.

Consultant Fees: We will pay the charges, not to exceed \$125 for the services of a medical consultant, upon referral by the attending Physician.

When approved by the Director of Adelphi Health Service Center, three return consultation visits will be payable up to \$125 per visit.

Outpatient Medical Expense: We will pay the charges, not to exceed \$100 (in excess of the Deductible Amount) for medical services and supplies for which benefits are not payable under any other provision of the Policy. The medical services and supplies must be prescribed by the attending Physician and provided on an outpatient basis. (The Deductible Amount for this benefit is \$25 if not referred by the Adelphi Health Service Center, and \$0 if referred by the Adelphi Health Service Center.)

Outpatient Diagnostic X-Ray and Laboratory Expense: We will pay the charges, not to exceed \$100, for outpatient diagnostic X-rays and laboratory expenses when they have been ordered by the Attending Physician.

Sickness Dental Expense: We will pay the charges for such expense, not to exceed \$50 if an Insured Person is Hospital confined, or an amount not to exceed \$25 for outpatient treatment. Sickness Dental Expense includes charges for the removal of impacted wisdom teeth or the treatment of dental abscesses.

Psychiatric Consultant Expense: We will pay up to \$175 for consultation on an outpatient basis by a legally qualified psychiatrist or a licensed psychologist when deemed necessary and requested by the Adelphi Health Service Center.

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

Prescription Drugs Expense: Up to \$250, for drugs and medicines prescribed by the attending physician and dispensed by Adelphi Health Service Center.

SECTION III

SUPPLEMENTAL MEDICAL EXPENSE BENEFIT

If the covered medical expense for your accident exceeds \$2,000 or Sickness exceeds \$2,500, we will pay 80% of the Expense up to an aggregate maximum of \$25,000.

The services must be rendered within 52 weeks of the date of accident or sickness. Covered expenses for daily hospital room and board will not be more than the usual semi-private room charge or Intensive Care Unit rate if applicable.

IMPORTANT: SECTION II BASIC SICKNESS MEDICAL EXPENSE MUST BE PURCHASED FOR THE ENHANCED SUPPLEMENTAL MEDICAL EXPENSE COVERAGE TO APPLY.

**SECTION IV
ENHANCED SUPPLEMENTAL MEDICAL
EXPENSE BENEFIT**

This benefit brings the total policy maximum per Injury or Sickness to \$50,000.

This Benefit may be added to **Sections I, II and III** by paying an additional premium. Only those enrolled in the **Sickness Medical and Supplemental Medical Expense Benefits (Section II and III)** may enroll in the **Enhanced Supplemental Medical Expense Benefit**.

Payment will be made for Covered Medical Expenses incurred within 52 weeks of the date of accident or sickness for any one Injury or Sickness in excess of \$25,000 up to a Maximum Benefit of an additional \$25,000 payable under this benefit for each Injury or Sickness. Covered Medical Expenses are usual and customary medical expenses incurred while insured as defined in the Policy.

Part 4 — 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.

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 charges incurred for such services. Expenses 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 charges 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 expenses 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 charges 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 of Alcoholism and Substance Abuse - We will pay the charges 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 charges for the diagnosis and treatment of alcoholism, alcohol abuse or substance abuse, We will pay the reasonable charges 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 expenses 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 expenses 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 and the patient to be appropriate; 3.) We will pay the expenses 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 expenses 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 expenses 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 expenses 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 charges 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 expenses 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 expenses 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 contra-indicated 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 syndrome 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.

Medical Evacuation and Repatriation

(Applies to Students who elected to purchase coverage under Section II.)

Medical Evacuation: If the Insured must be transported to his or her home country or state of origin for continuing medical treatment of a covered Injury or Sickness, We will pay expense of such transportation, not to exceed a total of \$10,000 with no deductible or coinsurance. This benefit will be paid provided: (1) as the result of a covered Injury or Sickness, the Insured has been hospital-confined for a period of at least five days for which benefits are payable under the Policy; and (2) such evacuation has prior approval of both the attending Physician and the Company.

International Students Only - Upon such evacuation, all coverage under the Policy for the Insured will terminate.

Repatriation: If the Insured dies as the result of a covered Accident or Sickness while insured under the Policy, We will pay the reasonable expenses for the preparation and transportation of the body to the Insured's country or state or origin. The benefits payable may not exceed a total of \$10,000. This

benefit does not pay for the transportation of any person accompanying the body.

Part 5 — Exclusions

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;
- treatment of mental or emotional disorders for:
a) individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the office of children and family services; b) services solely because such services are ordered by a court; or c) services determined to be cosmetic on the grounds that changing or improving individual's appearance is justified by the individual's mental health needs.
- inpatient treatment of alcoholism or drug addiction, except as may be provided by the policy;
- war or any act of war, whether declared or undeclared;
- participation in a felony, riot or insurrection;
- travel in, or descent from an aircraft, except when a fare-paying passenger;
- service in any armed forces, military reserves or militia; or

Nor does the policy provide benefits for:

- eyeglasses, contact lenses, hearing aids, or examinations for same;
- 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 it 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 by a person or facility employed or retained by the school;
- treatment or service provided by an Immediate Family Member or by a member of an Insured Person's 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, or as provided under the sickness dental expense benefit;
- preventive medicines, serums or vaccines.

Part 6 — 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 Claims Administration 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 7 — 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 the Adelphi Health Service Center so that proper treatment can be prescribed or approved.
2. If away from the College, consult a physician and follow the physician's advice. Notify the Adelphi Health Service Center within thirty (30) days after the date of the covered accident or commencement of the covered illness, or as soon thereafter as is reasonably possible.
3. Written proof of loss and itemized bill(s) must be furnished with your claim within ninety (90) days after the date of the Loss.

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 Plan Administrator at the address on the next panel.

MEDEX ASSISTANCE SERVICES

MEDEX assures the proper coordination and monitoring of medical care while the insured student is traveling outside of the United States. Their services include:

- Assistance in locating the nearest, most appropriate medical care
- Evaluation and monitoring of treatment
- Management of medically necessary evacuations and repatriation of mortal remains
- Blood, vaccine and medication transfers worldwide
- Maintaining contact with family members, personal physicians and employers
- Emergency translation services
- Facilitation, hospital admission and discharge plan
- Coordination of direct payments to providers
- Emergency international transfer of funds
- Legal referral assistance
- Assistance with replacing lost or stolen travel documents

A toll-free or collect call immediately links you to MEDEX's highly trained, multilingual assistance coordinators, 24 hours a day, every day of the year, call:

1-800-527-0218
Program No. 570

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 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, Security Mutual Life Insurance Company of New York has caused this Endorsement to be signed by its President and Secretary.



Secretary



President

Plan Administrator:

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

The Plan Is Underwritten by:

Security Mutual Life Insurance Company of New York
Binghamton, NY

as policy form # SML-100

***For a copy of the Company's or Claims Administrator'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.

Limited Benefits Health Insurance

The insurance evidenced by this brochure provides limited benefits health insurance only.

***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.

Consultant:

Mercer Health Benefits Inc.
1166 Avenue of the Americas
New York, NY 10036