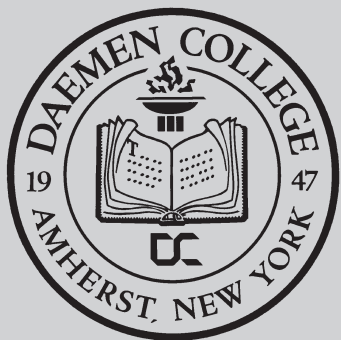


2005–2006 STUDENT HEALTH INSURANCE PROGRAM

*A Guide
For Students
Attending*



Policy # 2005M2A00

Underwritten by:
**COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY**

Utica, NY

as policy form # SH-1-88

STUDENT HEALTH INSURANCE PROGRAM

The following is a brief description of an Accident and Sickness Insurance Plan designed for students attending Daemen College. The Master Policy issued to the College (the Policyholder) contains the complete details of coverage and is the governing document. It may be inspected during normal business hours at the Student Health Service.

ELIGIBILITY

All resident and international students are eligible and must be enrolled in this insurance plan unless proof of comparable coverage is furnished. All other students are eligible to enroll in this insurance plan on a Voluntary basis. The annual cost of this coverage for students is \$746.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased unless they would have been eligible to attend classes for 31 days and were prevented from attending due to a Sickness or Injury. Home study, correspondence, and television (tv) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the Policy Eligibility requirements have been met. If and whenever the Company discovers that the Policy Eligibility requirements have not been met, its only obligation is refund of premium.

Eligible Dependents are the Insured Student's spouse and unmarried children who are 19 years of age and under and reside with the Insured Student. To obtain an enrollment form contact the Health Services Office.

DEPENDENT COVERAGE

An Insured Student may enroll dependents (spouse and unmarried children up to age 19 who are not self-supporting) by completing an enrollment form and paying the appropriate premium each semester. Premiums for dependent coverage are as follows:

	Annual
Spouse	\$1,193
Child	\$1,193

If an Insured gives birth to a child while coverage is in effect for such student or spouse, coverage for the child will be provided for injury, sickness, medically diagnosed congenital defects, and birth abnormalities or premature

birth for thirty (30) days from the moment of birth. This coverage will cease at the end of the 30 day period if an enrollment form and premium (if due) for the child have not been received.

To obtain a dependent enrollment form, visit the Health Services Office. All premiums must be paid by check or money order.

TERMS OF COVERAGE

The Master Policy on file at the school becomes effective at 12:01 a.m., August 20, 2005. Coverage becomes effective on that date or the date application and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 12:01 a.m., August 20, 2006. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

You must meet the Eligibility requirements listed above each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received prior to the enrollment deadline. It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage. The Policy is a Non-Renewable One Year Term Policy. It is the Insured's responsibility to obtain coverage the following year in order to maintain continuity of coverage. Insureds who have not received information regarding a subsequent plan prior to the Policy's Termination Date should inquire regarding such coverage with the school or its agent.

REFUND OF PREMIUM

Premium received is fully earned upon receipt. Refund of premium will be considered only as specifically provided above: i.e., early withdrawal from the College for entry into the armed forces. ***No other refunds will be allowed.***

**CERTIFICATE OF
STUDENT BLANKET HEALTH INSURANCE**

issued by

**COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
Utica, New York 13502**

(Herein called "the COMPANY")

The COMPANY hereby certifies that the eligible student of the Policyholder named on the Student Identification Card is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form SH-1-88 ("the Policy").

Limited benefits health insurance. The insurance evidenced by this certificate provides limited benefits health insurance only.

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Part I—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.

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, hospital, 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.

Pre-Existing Condition means the existence of symptoms which would ordinarily cause a prudent person to seek diagnosis, care or treatment within a six-month period preceding the effective date of the coverage of the Insured Person, or a condition for which medical advice or treatment was recommended by a physician or received from a physician within a six-month period preceding the effective date of coverage of the Insured Person.

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.

If the Insured Person is totally disabled on the date of termination of coverage, an extension of benefits will be provided during such disability for hospital confinements commencing or surgery performed during the next 31 days for the injury or sickness causing the total disability.

Part 2—Basic Medical Expense Benefits

For Accidents

When injury requires treatment, payment will be made up to a maximum benefit of \$1,000, subject to a \$25 deductible, for covered medical expense resulting from each accident occurring during the term insured. The Deductible will be waived if the Insured utilizes Family Care Medical Center and/or MedFirst or when referred by Family Care or the Health Services Office. Covered medical expense are those expenses for physicians, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other reasonable and customary medical expense incurred while insured under the Policy. Injuries to sound, natural teeth are covered on the same basis as any other injury.

For Sickness

When hospital or medical care is required for sickness first manifesting during the term insured, payment will be made as allocated below for covered medical expense not to exceed \$1,000, subject to a \$25 deductible, for any one sickness under this Benefit. The Deductible will be waived if the Insured utilizes Family Care Medical Center and/or MedFirst. Maternity expense and complications of pregnancy, conception occurring during the term insured, are covered on the same basis as sickness.

Hospital Room and Board Expense: The semi-private room rate, up to \$225 per day for hospitalization and \$500 per day for ICU when medically necessary and ordered by an attending physician.

Miscellaneous Hospital Expense: Up to \$500 for X-ray examinations, laboratory tests, anesthesia, medicines, use of operating room, oxygen tent, drugs, medicines, dressings and other necessary and prescribed miscellaneous hospital expense when the Insured is confined as a bed patient in a hospital, or as an outpatient for day surgery.

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

Surgeon Expense (in or out of hospital): Up to 100% of Usual & Customary charges up to a maximum of \$1,000.

Physician's Expense (when hospital confined): Up to \$50 per visit for hospital visits, limited to one visit per day. The physician may not be the surgeon who operated on you.

Anesthetist Expense: Up to 25% of the amount payable for Surgery.

Assistant Surgeon Expense: Up to 25% of the amount payable for Surgery.

Inpatient Nurse Expense: We will pay the charges, not to exceed \$50 per day during any one 24-hour period, up to 10 days, while an Insured Person is confined to a Hospital. Services of a licensed registered or practical nurse must be: 1) authorized by the attending Physician; and 2) provided by a nurse who is not a regular staff member of the Hospital in which an Insured Person is confined.

Physician's Expense (when not hospital confined): Up to \$50 for the first visit and \$40 each subsequent visit for outpatient services, not to exceed 10 visits, limited to one visit per day. The physician may not be the surgeon who operated on you. Benefits begin with the first visit. A \$5.00 per visit deductible will apply. This benefit will include consultation with a physician for prescription contraceptives.

Consultant Expense: Up to \$100 for the services of a consultant or specialist when such services are deemed necessary and ordered by a Family Care Medical Center and/or MedFirst physician for the purpose of confirming or determining a diagnosis. The attending physician must order such services for dependents.

Ambulance Expense: Up to \$200 for an ambulance when such transportation is required due to the emergency nature of a sickness.

Hospital Outpatient Expense: Up to \$500, for outpatient X-rays, laboratory tests and the use of an emergency or operating room.

Emergency Medical Expense: We will pay the charges for emergency medical services provided by a Hospital not to exceed \$1,000. Such emergency services must be pro-

vided within 24 hours after the appearance of symptoms of a Sickness. No payment will be made for such charges if they are payable under any other provision of the policy.

Outpatient Diagnostic X-Ray and Laboratory Expense: We will pay the charges, not to exceed \$750 for outpatient diagnostic X-rays and laboratory expenses when they have been ordered by the Attending Physician or referred by Family Care Medical Center and/or MedFirst.

Prescribed Medicine Expense: Up to \$125 per sickness for prescribed drugs and medicines per semester, subject to a \$5.00 co-pay.

Sickness Dental Expense: Up to \$50 per tooth on an inpatient basis and \$25 per tooth on an outpatient basis for the treatment of impacted wisdom teeth and dental abscesses. No other Policy benefits are payable.

Inpatient Mental and Emotional Disorders: Up to \$1,000 per condition.

Mammograms and Pap Smears: We will pay the charges incurred for the following cancer screening tests: (1) a baseline mammogram for women ages 36 to 39, inclusive; (2) screening mammogram performed at least once a year for women 40 years of age and over; and (3) PAP tests for women 18 years of age and older as recommended by a Physician.

Outpatient Alcohol/Substance Abuse or Dependence Expense: Up to sixty (60) outpatient visits per calendar year for the diagnosis and treatment of alcoholism, alcohol abuse, substance abuse or substance dependence in a facility approved by the New York State Division of Alcoholism and Alcohol Abuse of the Division of Substance Abuse Services. Up to twenty (20) of these visits may be used for family counseling of covered dependents.

Part 3—Supplementary Medical Expense Benefits

Payment will be made for eighty percent (80%) of covered medical expense incurred for an injury or sickness in excess of \$1,000, to a maximum payment of an additional \$24,000 (\$8,000 for Inpatient Mental and Emotional disorders) payable under this Benefit for each accident or sickness. Covered medical expense are those expenses for physicians, surgeons, dentists, hospital confinement, X-rays, laboratory tests, nurses, prescribed medicines, casts, surgical dressings, use of an ambulance, and other reasonable and customary medical expense incurred while insured under the Policy.

Part 4—Additional Benefits

Accidental Death and Dismemberment Indemnity

If the Insured Person sustains any of the following losses as the result of a covered accident, within 26 weeks after the date of accident, the COMPANY will pay the amount shown.

For Loss of	Benefit
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.

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 100% 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 - 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 dia-

betes 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 Chemical Abuse and Dependency Treatment Expense - 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 as a result of alcohol dependence or substance dependence - inpatient benefits in a Hospital or detoxification facility of seven (7) days of active treatment in a consecutive 12 month period; and b.) Rehabilitation services - limited to 30 days of inpatient care in a consecutive 12 month period.

Such 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 programs.

Outpatient Treatment of Chemical and Dependency 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, vis-

its 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 treat-

ment 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.

Part 5—Limitations of Coverage

The Policy does not cover any loss contributed to or resulting from:

1. the practice or play of interscholastic sports;
2. suicide or attempted suicide, or any self-inflicted injury;
3. mental or emotional disorders, except as specifically provided by the policy;
4. inpatient treatment of alcoholism or drug addiction, except as may be provided by the policy;
5. war or any act of war, whether declared or undeclared;
6. participation in a felony, riot or insurrection;
7. travel in, or descent from an aircraft, except when a fare-paying passenger;
8. service in any armed forces, military reserves or militia; or
9. preexisting conditions during the first 12 months of continuous coverage.

However, this provision will not limit benefits for a Preexisting Condition if, during the 60 day period immediately preceding the Insured's becoming insured under the policy, he or she was enrolled as a member under another policy or plan that provided similar benefits.

Nor does the Policy provide benefits for:

1. eyeglasses, contact lenses, hearing aids, or examinations for same;
2. expenses for which benefits are paid under any Workers' Compensation law or similar law or under any mandatory no-fault automobile insurance;
3. cosmetic surgery, except reconstructive surgery when it is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
4. treatment provided in a governmental Hospital, unless there is a legal obligation to pay for such service in the absence of insurance;
5. treatment by a person or facility employed or retained by the school;
6. treatment or service provided by an Immediate Family Member or for a member of an Insured Person's household for which no charge is normally made;
7. voluntary or elective abortion;
8. dental care or treatment, except for injury to sound natural teeth caused by an Accident;

9. preventive medicines, serums or vaccines; and
10. expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefit Provisions.

TERMINATION OF INSURANCE

Benefits are payable under the Policy only for that covered expense incurred while the Policy is in effect as to the Insured. No benefits are payable for expense incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

EXTENSION OF BENEFITS

If an Insured is totally disabled on the date his or her insurance ends, the term "Expense" includes charges incurred after the date such insurance ends. But this only applies to hospital confinements which start or surgery performed within ninety (90) days after the date such insurance ends. The hospital confinement or surgery must be only for the care or treatment of the injury or sickness which caused the total disability.

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 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 occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss: Written proof of loss must be furnished to the COMPANY at its said office within ninety 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 an 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 acknowledgment 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

To the event of Accident or Sickness the student should:

1. If at the College, report immediately to the Student Health Services so that proper treatment can be prescribed or approved.
2. If away from College, consult a doctor and follow his or her advice. Notify Student 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 Student Health Services.
4. Complete the form.
5. Submit the claim form, complete with bills and receipts, to Student Health Services.
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.

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


Secretary


President

Underwritten by:

Commercial Travelers Mutual
Insurance Company
Utica, NY 13502
1-800-756-3702

as policy form # SH-1-88

***For a copy of the Company's
Privacy Notice, go to:***

www.commercialtravelers.com/privacy.html

Local Representative

M&T Insurance Agency, Inc.
334 Delaware Avenue
Buffalo, NY 14202

***Representations of this plan
must be approved by the Company.***

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.

This booklet contains
the Certificate of Insurance for students
insured under the 2005–2006 Student
Accident and Sickness Plan for
Daemen College