Policy Form 9F147

CERTIFICATE OF COVERAGE

ACCIDENT AND SICKNESS INSURANCE

A Non-Renewable Term Policy
For Students Attending

STATE UNIVERSITY OF NEW YORK AT GENESEO 2012 – 2013

Underwritten by

COLUMBIAN MUTUAL
LIFE INSURANCE COMPANY
HOME OFFICE: VESTAL PARKWAY EAST
P.O. BOX 1381 • BINGHAMTON, NY 13902-1381

SERVICING AGENT
Niagara National Inc.
5001 Genesee Street
Buffalo, NY 14225
(800) 444-5530

Keep this certificate as a summary of your coverage - no individual policy will be issued - a master policy #31-67-0103-029-610-2 is issued to the University. The Master Policy contains the contract provisions and shall prevail in the event of a conflict between this certificate and the Master Policy. PRIVACY POLICY: You may obtain a detailed copy of Columbian Mutual's privacy policy by contacting Student Assurance Services, Inc. ("SAS") the Plan Administrator at (800) 328-2739, or by visiting our website www.sas-mn.com.

Dear Student:
The administration is making available to the students and their dependents, a plan of blanket accident and sickness insurance (hereinafter called "plan" or "Plan") underwritten by Columbian Mutual Life Insurance Company. Any questions about the policy should be directed to:

Niagara National Inc.
5001 Genesee Street, Buffalo, NY 14225
(800) 444-5530

ELIGIBILITY

All registered students are eligible to enroll in the accident and sickness insurance plan on a voluntary basis.

Students must be physically and actively attending classes on campus. Students age 65 or over, online or distance learning students solely taking off-campus home study, correspondence, or television courses are not eligible to enroll in the plan. Coverage will become invalid for students who leave the University within 31 days of their effective date of coverage. The Plan Administrator should be notified at that time by the student. Students who enroll in the accident and sickness insurance plan may secure family coverage. Dependents must enroll when the student first enrolls and must enroll for the same coverage as the student. Eligible dependents are the spouse residing with the insured student, and unmarried children under twenty-six years of age who are not self-supporting and reside with the insured student. Eligible dependent includes a child for whom the Insured is required to provide coverage by court or administrative order. Contact the Plan Administrator for further information.

EFFECTIVE AND EXPIRATION DATES

Your coverage becomes effective on the later of: the Master Policy effective date 08-23-2012; the first day of the term for which the proper premium has been paid; or 12:01 a.m. following the date the proper premium is received by the Plan Administrator. All coverage expires on the earlier of: the Master Policy expiration date of 08-22-2013, or when premium for the insurance coverage is due and unpaid. Dependent coverage will not be effective prior to that of the student. Dependent coverage expires concurrently with that of the student.

ENROLLMENT PERIOD - LATE ENROLLMENT

Eligible students and dependents may enroll for annual coverage no later than the enrollment period deadline date of **09-24-2012.** New students registering with the University for Spring term, must enroll no later than **02-21-2013.** If we receive premium payment after the effective date of coverage for the term enrolling, coverage becomes effective 12:01 a.m. following the date the proper premium is received by the Plan Administrator. **We do not accept enrollment forms and premium payments after the enrollment period deadline date, unless the student or dependent qualifies for late enrollment.** To qualify for late enrollment, an enrollment form and premium payment must be received by the Plan Administrator no later than 30 days after the qualifying event of involuntary loss of coverage under another health plan, marriage or birth/adoption of child. Contact the Plan Administrator or servicing agent for enrollment information and partial year rates.

CONTINUOUS COVERAGE

Coverage will be considered continuous, if you were covered to the policy expiration date of your prior student health insurance policy of the policyholder, and you enroll for coverage under the Policy and pay the required premium within 63 days of the expiration date of the prior student health insurance policy. You will not be denied benefits under the Policy for a pre-existing condition or an injury or sickness covered under your prior student health insurance policy, unless under the Policy the injury or sickness expenses incurred are not considered a covered service, or benefits are limited by other provisions in the Policy. If the prior policy was with us, benefits will not be paid under the Policy if any applicable maximum has been exhausted.

TO ENROLL FOR COVERAGE

1) To enroll and pay by credit card, complete the online enrollment form located on the Student Assurance Services Inc. website **www.sas-mn.com**. The online form is located under “Find My School”.
2) To enroll and pay by check or money order, complete the enrollment form or download and print an enrollment form from the website **www.sas-mn.com**. Complete the form and send it with your payment to:

Student Assurance Services Inc.
P.O. Box 196, Stillwater, MN 55082.

TO OBTAIN MORE INFORMATION

To check the status of your filed claim, ask questions regarding receipt of premium, or to verify coverage contact the claims office from 8:00 a.m. to 4:30 p.m. (Central Time), Monday through Friday. Call Student Assurance Services, Inc. toll free at **(800) 328-2739 or** refer questions on our website **www.sas-mn.com**.

MEDICAL BENEFITS SCHEDULE

Benefits are payable only for expenses incurred during the policy benefit period. No benefits are payable for expenses incurred prior to or after the insured's effective or expiration dates respectively. The Policy does not provide benefits for services which are not listed in the Schedule of Benefits. Pre-existing conditions, experimental and investigational services, and elective surgery or treatment are not covered services. Medical expenses are payable at the in-network covered percentage for the preferred provider negotiated fee or out-of-network covered percentage for the non-preferred provider usual and customary charges (U&C) incurred, less any deductible or copay if applicable. Benefits are payable for each covered injury or sickness up to the aggregate policy year maximum. In addition to the policy year maximum, the Policy may contain benefit-level maximums for a covered service, as outlined in the Schedule of Benefits. The insured is responsible for the co-insurance or the balance of expenses not paid by the Policy.

	In-Network	Out-of-Network
Basic Aggregate Maximum Benefit – policy year	**$100,000**	**$100,000**
Basic Deductible – per person, each covered injury or sickness	**$50**	**$300**
Benefits are payable at the following covered percentage-each covered injury or sickness:		
- For the first $2,000 in paid benefits	**80%**	**60%**
- For the next $73,000 in paid benefits	**60%**	**50%**
- For the next $25,000 in paid benefits	**100%**	**90%**

COVERED SERVICES

1. INPATIENT

a. HOSPITAL ROOM AND BOARD, HOSPITAL INTENSIVE CARE, AND HOSPITAL MISCELLANEOUS (services and supplies including but not limited to: the cost of the operating room; laboratory tests; x-ray examinations; anesthesia; drugs - excluding take-home drugs or medications; supplies and 24-hour nursing care) ..... Covered percentage listed above; semi-private room rate; after $500 copay per confinement

b. SURGICAL TREATMENT ..... Covered percentage listed above

c. ANESTHETIST AND ASSISTANT SURGEON ..... Covered percentage listed above

d. PHYSICIAN'S NON-SURGICAL VISITS (1 visit per day; not paid same day as surgery; includes consultant physician) ..... Covered percentage listed above

e. PRE-ADMISSION TESTING (3 working days prior to admission) ..... Covered percentage listed above

f. MATERNITY BENEFITS ..... Same as any Sickness

g. MENTAL AND NERVOUS DISORDERS ..... Same as any Sickness; up to 30 days per policy year

h. SUBSTANCE ABUSE ..... Same as any Sickness; up to 7 days per policy year

i. PHYSIOTHERAPY (when prescribed by the attending physician) ..... Covered percentage listed above; 1 visit per day; up to maximum 30 visits

j. PRIVATE DUTY NURSE (when medically necessary) ..... Covered percentage listed above

k. PATHOLOGY AND RADIOLOGY ..... Covered percentage listed above

l. CHEMOTHERAPY AND RADIATION THERAPY ..... Covered percentage listed above

2. OUTPATIENT

a. HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS ..... Covered percentage listed above; after $500 copay

b. SURGICAL TREATMENT ..... Covered percentage listed above

c. ANESTHETIST AND ASSISTANT SURGEON ..... Covered percentage listed above

d. PHYSICIAN'S NON-SURGICAL VISITS (1 visit per day; not paid same day as surgery; includes consultant physician) ..... Covered percentage listed above; after $25 copay per visit; up to maximum 30 visits

e. PHYSIOTHERAPY (when prescribed by the attending physician) ..... Covered percentage listed above; 1 visit per day; up to maximum 10 visits

f. HOSPITAL EMERGENCY ROOM (copay waived if admitted) ..... Covered percentage listed above; after $150 copay per visit

g. DIAGNOSTIC, X-RAY , AND LAB SERVICES ..... Covered percentage listed above

h. MENTAL AND NERVOUS DISORDERS ..... Same as any Sickness; up to 20 visits per policy year

i. MATERNITY BENEFITS ..... Same as any Sickness

j. PRESCRIPTION DRUGS (30-day supply per prescription) ..... In-Network covered percentage listed above; after $25 copay per generic drug or $50 copay per brand drug

k. SUBSTANCE ABUSE ..... Same as any Sickness; up to 60 visits per policy year

l. CHEMOTHERAPY AND RADIATION THERAPY ..... Covered percentage listed above

m. SHOTS AND INJECTIONS (administered in physicans office) ..... Covered percentage listed above

3. OTHER

a. AMBULANCE SERVICES (Ground service) ..... In-Network covered percentage listed above

b. PREVENTIVE CARE (routine office visit, pap smear, lab services, deductible does not apply) ..... In-Network - 100% U&C
Out-of-Network - No Benefit

c. DENTAL TREATMENT (Injury to sound, natural teeth, includes x-rays, does not include biting or chewing injuries) ..... Covered percentage listed above, up to maximum $150

d. DURABLE MEDICAL EQUIPMENT AND ORTHOPEDIC APPLIANCES ..... Covered percentage listed above; after $100 copay per prescription

e. MOTOR VEHICLE INJURY ..... **Inpatient**: Same as any Injury; **Outpatient**: Same as any Injury, up to maximum $1,000

f. INPATIENT NEWBORN CARE ..... Same as any Sickness; up to 48 hours for vaginal delivery; or 96 hours cesarean delivery

NOTE: Premium includes an additional accident injury benefit for student athletes participating in intercollegiate sports. This benefit is provided in a separate policy issued to the University. The policy pays benefits up to maximum $2,000, after $50 deductible per sports injury. Contact the Plan Administrator for copy of the certificate.

For specific costs and further details of coverage, including exclusions, reductions or limitations, contact your Servicing Agent or write the Plan Administrator.

PREMIUM	**ANNUAL** 08-23-2012 to 08-22-2013	***SPRING TERM** 01-21-2013 to 08-22-2013
Student Only	$ 1,957	$ 1,155
Spouse	$ 6,522	$ 3,848
Each Child	$ 4,692	$ 2,769

Premium includes an agent service fee.

*Spring term may be purchased by a new student not previously eligible to enroll for annual coverage

MANDATED BENEFITS

Benefits mandated by the State of New York are made a part of the Policy. They include treatment for Outpatient Chemical Dependency, Alcoholism and Substance Abuse; Breast Reconstruction Surgery; Chiropractic Care; Diabetes; Off Label Drug; Breast Cancer Treatment; Screening for Cervical and Prostate Cancer; Mammography; Minimum Pregnancy Stays; Second Opinion; Prehospital Ambulance Emergency Services; Experimental or Investigational Treatments; Bone Mineral Density Tests; Drugs or Devices for Osteoporosis; Contraceptive Methods; Dental Treatment; TMJ Treatment; Cosmetic Surgery; Home Care; Enteral Formula; End of Life Care Coverage; Preadmission Tests; and Mental and Nervous Disorders. Benefits may be subject to deductibles, coinsurance, limitations, and exclusions of the Policy. A description of these Mandated Benefits can be found in the Master Policy on file at the University or call the Claim Office.

CREDITABLE COVERAGE

In determining whether a pre-existing condition waiting period applies, the Policy shall credit the time you were covered under prior creditable coverage. The prior creditable coverage must be continuous to a date not more than sixty three (63) days prior to the enrollment date under the Policy. Periods of coverage under several prior health plans may be added together, provided there is no break in coverage 63 continuous days or more. If you were covered by more than one health plan, only one day of prior creditable coverage is credited for each day your dual coverage existed. You must show proof of prior creditable coverage by submitting a certificate or other satisfactory evidence of coverage. The pre-existing condition waiting period shall not exclude coverage in the case of:

(a) an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under prior creditable coverage; or
(b) a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under prior creditable coverage, or
(c) The individual or dependent of the individual is eligible for a federal tax credit under the federal trade adjustment assistance reform act of 2002 and who has three months or more of prior creditable coverage.

Paragraphs (a) and (b) no longer apply to an individual after the end of the first sixty three (63) day period during all of which the individual was not covered under any prior creditable coverage.

ADDITIONAL PROGRAMS

These programs are not underwritten by Columbian Mutual Life Insurance Company.

If you participate in the student insurance plan, the following programs are available to you. More detailed program information will be sent to you with your ID card.

Travel Assistance – The global emergency services program is provided by Scholastic Emergency Services. The program provides 24-hour assistance whenever the student travels more than 100 miles away from the permanent residence, campus location, or in another country. International students are eligible for services on and away from campus. Services include emergency evacuation, supervised repatriation and return of mortal remains.

Ask Mayo Clinic – This program provides you telephone access to registered nurses. The program is administered through Mayo Foundation. You can call with questions about an illness, injury, or medical concern, 24 hours a day, 7 days a week.

Preferred Provider Network: Student Assurance Services, Inc. has contracted with MultiPlan Inc. a preferred provider network, to provide a discount for services received from physicians and hospitals participating in the MultiPlan network. To take advantage of this discount in your area, please use a MultiPlan in-network provider. In the Medical Benefits Schedule of this brochure, benefits will be paid at the covered percentage shown for the in-network negotiated fee when MultiPlan provider is used and the covered percentage shown for the U&C charges when a out-of-network provider is used. Please confirm your provider is a member of the MultiPlan network prior to receiving services. Benefits will be considered at the in-network covered percentage when care is required for a medical emergency. A directory listing of participating providers may be obtained on the website www.multiplan.com or call 888-342-7427.

EXCLUSIONS

The policy does not provide Benefits for expense resulting from:

1. Air flight, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline.
2. Dental treatment, except for such care or treatment due to Injury to sound natural teeth within 12 months of accident. This does not include dental care and treatment necessary due to congenital disease or anomaly.
3. Cosmetic surgery except reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
4. Motor vehicle Accidents, to the extent covered by another valid and collectible insurance policy, prepaid services contract, or similar plan, except as specifically provided in the Benefits Schedule.
5. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations.
6. Injury or Sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Injury sustained while participating in the practice or play of interscholastic or intercollegiate sports, including the participation in any conditioning program for such sport, contest or competition.
8. Intentional self-inflicted injuries; including drug overdose; Loss incurred while committing or attempting to commit a felony; or Loss due to voluntary participation in a riot or civil disturbance.
9. Services provided normally without charge by the Health Service of the Policyholder; or by any person employed or retained by the Policyholder; or services covered or provided by the student health fee.
10. Treatment of Mental and Nervous Disorders and Chemical Dependency, Alcoholism and Substance Abuse, except as specifically provided in the Benefits Schedule or per Mandated Benefits.
11. War or act of war, whether declared or not; and Injury or Sickness resulting from full-time, active-duty military service.
12. Pre-existing Conditions; not subject to Prior Creditable Coverage, and until continuously covered by the University's Student Accident and Sickness Insurance plan for a period of 12 consecutive months.
13. Rest cures, custodial care and transportation.

DEFINITIONS

Elective Surgery and Elective Treatment means surgery or medical treatment which is not necessitated by a pathological change occurring after your effective date of coverage. Elective Surgery includes but is not limited to: tubal ligation; circumcision; vasectomy; breast reduction except when medically necessary to achieve symmetry following a mastectomy; sexual reassignment surgery; any services or supplies rendered for the purpose or with the intent of inducing conception; weight reduction or treatment of obesity; and submucous resection and/or other surgical correction for deviated nasal septum, other than for treatment of covered acute purulent sinusitis. Elective Treatment includes but is not limited to: allergy testing; treatment for acne; biofeedback-type services; cosmetic procedures; infertility; hypnotherapy; learning disabilities; acupuncture; treatment related to sleep disorders; growth hormone therapy; treatment for hair growth or baldness; and weight management services and supplies.
This does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
Injury means accidental bodily injury or injuries directly caused by specific accidental contact with another body or object while your coverage is in force. It is unrelated to any pathological, functional, or structural disorder or injury resulting directly and independently of all other causes, in loss covered by the Policy. All related injuries and recurrent symptoms of the same or similar condition will be considered one injury.
Pre-Existing Condition means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period ending on the enrollment date. Pre-existing condition does not include:
(a) Genetic information in the absence of a diagnosis of the condition related to such information, or
(b) Congenital anomaly of a covered dependent child.
Pre-existing Condition Waiting Period means the twelve (12) month time period you must have continuous coverage inforce under the Policy before a pre-existing condition is considered a loss. Except, the pre-existing condition waiting period for a pregnancy existing on the Enrollment Date is ten (10) months.
Refunds - A prorated premium refund, less an administration fee, will be made for the following situations if the Plan Administrator receives written notice and proof, including the date of occurrence that: a) the student has entered into full-time active-duty military service of any country; b) the student is a non-immigrant foreign national and has left the North American continent or c) the student withdraws from the University within 31 days of the effective date of coverage.
Prior Creditable Coverage means coverage provided in the United States under any individual or group health benefits plan, insurance policy or certificate, service contract or HMO contract, or any government health benefit plan. See Master Policy for a complete listing.
Sickness means your bodily sickness, mental sickness, or maternity which is not a pre-existing condition and which causes loss while your coverage is in force. Sickness includes pregnancy, complications of pregnancy and trauma related disorders due to injuries which otherwise do not meet the definition of an Injury. All related sicknesses and recurrent symptoms of the same or similar condition will be considered one sickness.

CLAIM PROCEDURE

Usually the healthcare provider will file all necessary bills on the insured's behalf. However some providers may require payment at the time the service is provided or may send the bill directly to the insured. In these instances, the insured should file a claim and send all itemized medical or hospital bills to Student Assurance Services, Inc. A company claim form is not required, unless the itemized billing statements do not provide sufficient information to process the claim. The insured can print a company claim form or complete an online form from the website **www-sas-mn.com**.
To obtain reimbursement for a prescription drug, the insured will need to pay for the prescription drug at the pharmacy and submit a copy of the drug label with a claim form to Student Assurance Services, Inc. Proof of loss must be submitted to the address below within 90 days from the date of injury or sickness or as soon as reasonably possible.

Send claims or inquiries to:
Student Assurance Services Inc.
P.O. Box 196
Stillwater, MN 55082-0196

HEALTH CARE REFORM

Columbian Mutual Life Insurance Company continues to monitor the impact of this legislation on student insurance plans, and shall comply with the law's requirements and timelines.

This policy provides limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 70 percent. This ratio is the portion of future premiums which the Company expects to return as benefits, when averaged over all people with this policy.

If your coverage ends under this plan and you obtain other coverage, student insurance qualifies as prior creditable coverage. A certification of coverage will be furnished upon written request to the Company.

SUPPLEMENT BROCHURE FOR
STATE UNIVERSITY OF NEW YORK AT GENESEO

This notice is required by the Healthcare Reform Law. It explains differences in the restrictions for annual dollar limits for group, individual, and student plans. It also gives notice to students under age 26 to check the parent's employer or individual insurance policy for enrollment eligibility.

Your student health insurance coverage, administered by Student Assurance Services, Inc. may not meet the group health or individual insurance minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that students have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: $100,000 on covered essential health benefits and other benefits including but not limited to: ambulatory care; emergency services; hospital services; maternity and newborn care; prescription drugs; laboratory, x-ray, and diagnostic services; preventive; chronic disease management; rehabilitative and habilitative care. If you have any questions or concerns about this notice, contact Student Assurance Services Inc. at 1-800-328-2739. Be advised that 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 insurance carrier or plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

PRECERTIFICATION AND REFERRALS

This insurance plan does not require pre-certification or referrals for emergency services, to obtain access to providers specializing in obstetrics or gynecology, or any covered service prior to the date the service is performed. Covered services will be evaluated for benefits when the claim is submitted to the Plan Administrator for payment. A verbal explanation of benefits does not guarantee payment of claims.

MATERNITY EXPENSES

Benefits are payable for the insured's covered services for maternity care, including hospital, surgical, and medical expenses. Routine nursery care during the insured's confinement is payable if the well newborn child and the student are enrolled in the plan.

Maternity and routine well newborn care are paid the same as covered expenses for any other sickness. Benefits are paid for:

1. a minimum of 48 hours of inpatient care following a vaginal delivery; and
2. a minimum of 96 hours of inpatient care following a caesarean section.

A decision to shorten the minimum inpatient coverage shall be made by the attending physician in consultation with the insured.

A sick newborn child or adopted child will automatically be covered for an injury or sickness, provided the student is covered under the Policy. Refer to the definition of "Dependent" for sick newborn eligibility.

PREVENTIVE SERVICES

The following preventive services are covered under the Policy without regard to any deductible, copay, or co-insurance:

1) evidence based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to covered person;
3) with respect to covered infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);
4) with respect to women, preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force), which will be commonly known as HRSA's Women's Preventive Services: Required Health Plan Coverage Guidelines.

The preventive services referenced above are covered when received from an in-network provider. No benefits are payable if the preventive services are provided by out-of-network provider.

Cost sharing may apply to services provided during the same visit as the preventive services. For example if a covered preventive service is provided during an office visit and the preventive service is not the primary purpose for the visit, the cost sharing would apply to the office visit.

Cost sharing may also apply for treatment that is not a covered preventive service, even if treatment results from a covered preventive service, or for any item or service that has ceased to be a covered preventive service.

Reasonable medical management will be used to determine frequency, method, treatment, or setting for a preventive service. Also, any preventive service that is **not** on the list of recommended preventive services above is not covered or cost sharing may be applied.

RESCISSION

The Plan Administrator may rescind your coverage if the insured or insured's dependent commits fraud or makes an intentional misrepresentation of material fact. A notice will be provided at least thirty (30) calendar days before the coverage is rescinded. The insured may appeal any rescission.

PRE-EXISTING CONDITION EXCLUSION

The pre-existing condition exclusion does not apply for children or individuals enrolled in coverage who are under 19 years of age.

COVERAGE FOR DEPENDENT CHILD

Dependent coverage for children is available for an adult child until the child turns 26 years of age.