

2008-2009

**STUDENT
ACCIDENT AND SICKNESS
INSURANCE PLAN**

For the

International

Students of:



The Plan is serviced locally by:
M&T Insurance Agency Inc.
334 Delaware Avenue
Buffalo, NY 14202
716- 853-7960

Policy Number: UBM2828S

**For questions about this plan please
use the following contact information:**

Coverage, Eligibility and Premium:

Program Manager
The Allen J Flood Companies Inc.
2 Madison Ave.
Larchmont, NY 10538
1-800-734-9326
www.ajfusa.com

Claim Status and all other Claim Inquiries

Claims Administrator
AmeriBen/IEC Group.
POB 7186
Boise, ID 83707
Toll Free: 1-800-504-0142
[https:// services.ameriben.com](https://services.ameriben.com)
Case # 0807011

The Plan is serviced locally by

M&T insurance Agency Inc.
334 Delaware Avenue
Buffalo, NY 14202
1 716-853-7960

The Plan is Underwritten By

United States Fire Insurance Company
by: Fairmont Specialty, a Division of
Crum & Forster
Policy No. UBM2828S

PPO Network Provider List

Online at: www.Beechstreet.com
1.800.432.1776

**When calling the above toll-free telephone
numbers, please have the name of your
school and the policy number (UBM2728S)
available.**

**TO ALL INTERNATIONAL STUDENTS OF
CANISIUS COLLEGE**

International Students face many challenges as they adapt to a foreign environment, far from home, family and friends. A Sickness or Injury during a student's stay in the United States can become an insurmountable challenge when faced with unplanned medical expenses. Canisius College therefore requires all international students, studying on visas, to purchase a health insurance plan, written just for international students, to cover most of the costs associated with health care in the United States. The plan outlined in this brochure helps to protect international students from financial burden and adds to the high quality academic and cultural experience Canisius is committed to providing international students.

Canisius College is pleased to announce that M&T Insurance Agency Inc. has arranged a Student Accident and Sickness Insurance Plan which provides up to 12 months of coverage, for the types of medical expense commonly incurred by college students. This Plan is underwritten by United States Fire Insurance Company and administered by The Allen J. Flood Companies, Inc. **The Policy Number for Accident Benefits is UBM2828S.**

EFFECTIVE AND TERMINATION DATES

The insurance under Canisius College's International Student Accident and Sickness Insurance Plan for the Annual Coverage is effective 12:01 a.m. on August 16, 2008 and terminates at 12:01 a.m. on August 16, 2009 or at the end of the period through which the premiums are paid. The Fall Coverage is effective August 16, 2008 and terminates December 31, 2008. The Spring Coverage is effective 12:01 a.m. on January 1, 2009, and will terminate at 12:01 a.m. on May 16, 2009. Summer Coverage is effective May 16, 2008 and will terminate on August 16, 2009. An eligible student's coverage becomes effective on the date the full premium is received by the Company or Plan Administrator, whichever is later.

The Policy expiration date for MBAs who are completing their course work will be 8/26/09.

Dependent coverage becomes effective on the date the Enrollment Form and full premium are received by the Company (or its authorized representative), whichever is later. Dependent coverage will not be effective prior to that of the insured student or extend beyond that of the

insured student and must be purchased at the same time that students enroll in the Student Accident and Sickness Insurance Plan.

ELIGIBILITY AND ENROLLMENT

All Registered F-1, full-time, part-time, undergraduate and graduate Students* studying on an F-1 visa, attending Canisius College, must purchase the International Student Accident and Sickness Plan outlined in this brochure. Students are enrolled in the plan by the Office of International Students Programs and billed for the plan by Canisius College along with tuition, room and board.

*Canadian full time, part time, undergraduate or graduate students enrolled at Canisius College, and taking 6 or more credits, are eligible, but not required to enroll in this plan. Canadian students interested in enrolling should contact the Office of International Student Programs upon registering at Canisius College.

DEPENDENT ENROLLMENT

Students who are enrolled in the Student Accident and Sickness Insurance Plan may also enroll their Dependents. The term "Dependent" means: (a) the Insured Student's spouse residing with the Insured Student; or (b) the Insured Student's unmarried children under the age of nineteen years, 19 but less than 25 years of age if a Full-time student; or (c) a child born to an Insured Student while this Plan is in force will be covered by this Plan from the moment of birth. Coverage for such newborn children will consist of coverage for sickness and injury, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child, for dependent benefits, for the first 31 days from the moment of birth. To continue the child's dependent benefits past the first 31 days, the Insured Student must notify the Plan Administrator in writing within 31 days of the child's birth.

The term children includes an Insured Student's biological children; step-children; adopted children beginning with any waiting period pending finalization of the child's adoption and who depend on the Insured Student for their full support. A child's coverage will not end because the child has reached the age limit shown above, if he or she:

(a) is not able to earn his or her own living as a result of physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance. **Insured Students who wish to purchase Dependent Coverage** should complete the Dependent Enrollment Form on the back of this brochure and return it with check or money order to The Allen J. Flood Companies, Inc. Two Madison Avenue, Larchmont, NY 10538. Dependent Coverage must be purchased at the same time that student enrolls in the Student Accident and Sickness Insurance Plan.

PREMIUM RATES & DATES OF COVERAGE

	Annual 8/16/08 to 8/16/09	Fall 8/16/08 to 12/31/08	Spring 1/1/09 to 5/16/09	Summer 5/16/09 to 8/16/09
Student	\$874.00	\$328.00	\$328.00	\$219.00
Spouse	\$2,755.00	\$1,033.00	\$1,033.00	\$689.00
Child (1)	\$1,283.00	\$481.00	\$481.00	\$326.00

IDENTIFICATION CARDS

The Student Identification Card should be picked up at the **Office of International Student Programs**. Please retain this card in a safe place. No other card will be issued to insured students. Identification cards for covered dependents will be provided by the Plan Administrator, The Allen J. Flood Companies, Inc. upon receipt of the completed enrollment form and the appropriate premium.

PREMIUM REFUND POLICY

Insured Students entering the Armed Forces of any country will not be covered under this Plan as of the date of such entry. Those students withdrawing from the school to enter military service will be entitled to a pro-rata refund of premium upon written request. Premium received by the Company is fully earned upon receipt. No other requests for a refund of premium will be considered.

DEFINITIONS

Covered Expenses means charges:

- a. Not in excess of Usual, Reasonable and Customary charge;
- b. Not in excess of the maximum benefit amount payable per service as shown in the Schedule;
- c. Made for medical services and supplies not excluded under the policy;
- d. Made for services and supplies which are Medically

Necessary; and

- e. Made for medical services specifically included in the Schedule.

Doctor means a licensed practitioner of the healing arts acting within the scope of his license. Furthermore Doctor includes any healthcare practitioner required under New York law providing a service covered under the policy. Doctor does not include;

- a. You;
- b. Your spouse, dependent, parent, brother or sister; or
- c. A person who ordinarily resides with You.

Injury means bodily harm resulting, directly and independently of disease or bodily infirmity, from an accident. All injuries to the same person sustained in one accident, including all related conditions and recurring symptoms of injuries will be considered one Injury.

Covered Person means the Covered Student and their eligible Dependent(s). If dependent coverage is available and the covered student has applied for such dependent coverage and paid the required premium.

Medical Emergency means the occurrence of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect in the absence of immediate medical attention to result in:

- a. Placing ones health (for a pregnant woman this includes the health of the newborn) in serious jeopardy;
- b. Serious impairment to bodily functions;
- c. Serious dysfunction of any body organ or part; or;
- d. Serious disfigurement of such person.

Usual, Reasonable and Customary Expense means

- a. Charges and fees for medical services or supplies that are the lesser of;
 - 1) The usual charge by the provider for the service or supply given; or
 - 2) The average charged for the service or supply in the area where service or supply is received; and
- b. Treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition.

Sickness means illness, disease, normal pregnancy, and Complication of Pregnancy that first manifests itself after the effective date of a Covered Person's coverage under the policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

PREFERRED PROVIDER NETWORK

This policy includes the voluntary utilization of Beech Street Nationwide Preferred Provider Network. Utilizing the Beech Street Nationwide Preferred Provider Network may decrease your out of pocket costs under this Accident and Sickness Insurance Plan. The Beech Street Network consists of hospitals, physicians and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. You are not required to utilize a Beech Street Provider. In order to use the services of a participating provider you must present your United States Fire Insurance Company Medical Identification Card. An Insured Person may contact Beech Street at 1-800-432-1776, toll free number available Monday through Friday, 8 a.m. to 8 p.m. to receive information on participants in their area, or visit their web site at www.beechstreet.com.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH BENEFIT

If a Insured Person's Injury results in loss of life within 365 days after the covered Accident, the Principal Sum of \$10,000 will be payable.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT

If an Insured Person incurs expenses while insured under the Policy due to a covered Injury or Sickness, We will pay 100% of the Covered Expenses listed below (unless otherwise specified). All Covered Expenses incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one Sickness or Injury. The amount payable for any one covered Sickness or Injury for the Covered Person will not exceed a maximum benefit limit of \$250,000, subject to the deductible amount and co-payment levels. The maximum benefit limit for a dependent is \$50,000 subject to the deductible amount and copayment levels. The expenses must be incurred within 52 weeks of the date of Injury or commencement of Sickness, and the Covered Person must remain continuously insured.

Deductible Amount. The deductible is \$100 per covered Injury or Sickness. The deductible will be zero (\$) if initial treatment is rendered at the Student Health Center.

If you are Sick or Injured, go directly to the Student Health Center at Canisius College in Frisch Hall. If the Student Health Center is closed and you need care, go to the closest hospital or seek care from a Doctor. The Student Health Center website www.canisius.edu/student_health has a list of urgent care clinics that will treat international students when the Health Center is closed. If your condition is life threatening and you need immediate care, go to the nearest hospital.

International Students who seek care outside the Student Health Center must notify the Student Health Center on the next business day after treatment. Notification can be done two ways (1) calling the Health Center at 716 888-2610, or (2) dropping by the Student Health Center.

The Student Health Center will assist all international students after they have been treated off campus. The Student Health Center will arrange for any needed follow up services as well as assist international students in filing a claim for expenses related to treatment at a hospital or Doctor's office.

COVERED EXPENSES

- 1) Diagnosis and treatment by a Doctor, surgeon, Registered Nurse, professional anesthetist, or radiologist.
- 2) Hospital charges, which include charges for all general nursing services, are limited to the semi-private room rate.
- 3) Intensive Care Facility charges.
- 4) Laboratory, diagnostic and x-ray examinations.
- 5) Drugs and medicines for Outpatient treatment which require a Doctor's written prescription and which can only be dispensed by a licensed pharmacist.
- 6) Rental of Durable Medical Equipment, or the purchase of this equipment, whichever is less.
- 7) Treatment of Outpatient Mental or Nervous Disorders.
See Additional Benefits
- 8) Treatment of Inpatient Mental or Nervous Disorders.
See Additional Benefits.
- 9) Treatment of Inpatient and Outpatient Drug and Alcohol Abuse. *See Additional Benefits*
- 10) Expenses incurred for professional ground ambulance service to the nearest Hospital.
- 11) Expenses incurred for treatment of Physiotherapy including acupuncture. Benefits are payable up to: (a) A maximum of 60 days on an inpatient basis, and (b) 15 visits up to a policy year maximum of \$500.

- 12) Expenses incurred for treatment of Injuries sustained as a result of covered motor vehicle accident
- 13) Expenses incurred as the result of a covered Pregnancy.
- 14) Repairs to sound natural teeth required due to an Injury. Benefits are limited to \$250 per tooth per Injury.
- 15) **Basic Physical Examination Benefit:** If a Covered Student, enrolling at Canisius College for the first time, requires a Physical Exam, We will pay the Covered Expenses incurred up to a maximum of \$100.
- 16) **Measles, Mumps, Rubella Vaccine Benefit (MMR):** If a Covered Student, enrolling at Canisius College for the first time, requires an MMR vaccine, We will pay the Covered Expenses incurred up to a maximum of \$55 only if services are received at the Student Health Center or referred to a Provider by the Student Health Center.
- 17) **PPD Skin Test Benefit :** If a Covered Student, enrolling at Canisius College for the first time, requires a PPD , We will pay the Covered Expenses incurred up to a maximum of \$15 only if services are received at the Student Health Center or referred to a Provider by the Student Health Center.
- 18) **Meningococcal Vaccine Benefit:** If a Covered Student, enrolling at Canisius College for the first time, requires a Meningococcal vaccine, We will pay the Covered Expenses incurred up to a maximum of \$100 only if services are received at the Student Health Center or referred to a Provider by the Student Health Center.
- 19) **Tetanus Diptheria Vaccine Benefit (TD):** If a Covered Student, enrolling at Canisius College for the first time, requires a TD vaccine, We will pay the Covered Expenses incurred up to a maximum of \$35 only if services are received at the Student Health Center or referred to a Provider by the Student Health Center.

TRAVEL ASSISTANCE SERVICES

The Travel Assist Plan is designed to provide students who travel 100 miles or more from their home (or in a foreign country that is not the country of permanent residence), with worldwide, 24-hour, emergency assistance services during the term of coverage under the student accident and sickness insurance. The assistance plan services are provided by On Call international (OCI).

Emergency Medical Transportation Services are provided by OCI up to a combined maximum limit of \$25,000 for covered services. Key services include:

- Emergency Evacuation
- Medically Necessary Repatriation
- Repatriation of Remains
- Family or Friend Transportation Arrangements
- Return of Minor Children

In addition to Emergency Medical Transportation Services Travel Assist Plan offers a variety of services such as: Medical Assistance, Travel Assistance and Pre-Trip Assistance.

Worldwide emergency medical, legal and travel assistance services are available 24 hours a day, 365 days a year. For more information, or detailed list of services, please call:

In the U.S., toll free – 1-866-509-7715
Worldwide, collect – 1-603-898-9159

24-HOUR NURSE ADVICE LINE

Wouldn't you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Member's ailments. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-800-850-4556.

ADDITIONAL BENEFITS

Mental, Nervous, or Emotional Disorder Benefit:

Benefits will be payable for Active Treatment of mental, nervous, or emotional disorders as follows.

Benefits are payable for inpatient hospital care for 30 days of active treatment per policy year in a hospital defined by Section 1.03(10) of the Mental Hygiene Law and 20 visits of active treatment per policy year for outpatient care in a facility issued an operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a psychiatrist or psychologist, or a professional corporation or university faculty practice corporation.

Benefits are payable the same as any other Sickness for inpatient hospital treatment for adults and children with biologically based mental illness and children with serious emotional disturbances.

Partial hospitalization days shall be covered with two partial hospitalization days equal to one covered inpatient day.

Definitions:

“Active treatment” means treatment furnished in connection with inpatient confinement for mental, nervous, or emotional disorders or ailments that meet the standards prescribed pursuant to the regulations of the commissioner of mental health. Active treatment for outpatient visits for biologically based mental illness or children with serious emotional disturbances will not require inpatient confinement to be eligible for outpatient treatment.

“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. Under the law, the following disorders satisfy the definition of biologically based mental illness: schizophrenia/psychotic disorders; major depression; bipolar disorder; delusional disorders; panic disorder; obsessive compulsive disorders, anorexia and bulimia.

“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: serious suicidal symptoms or other life-threatening self-destructive

behaviors; significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); behavior caused by emotional disturbances that placed the child at risk of causing personal injury or significant property damage; or behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household.

Exceptions to Coverage

Benefits do not apply to:

1. 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;
2. services solely because such services are ordered by a court; or
3. services determined to be cosmetic on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

Benefits provided will be subject to the same deductibles and coinsurance as any other Sickness. Benefits will be subject to the same network limitations, if any, as applicable to the other benefits provided under the Policy.

Inpatient Chemical Abuse and Chemical Dependence Expense Benefit: We will pay for such treatment as follows:

When the Covered Person is confined as an inpatient in a Hospital or a Detoxification Facility, We will pay up to seven (7) days of active treatment in any one calendar year. When the Covered Person is confined in a hospital or Chemical Abuse Treatment Facility, We will pay up to thirty (30) days of inpatient care for such services in any one calendar year.

As used in this provision, the term “Chemical Abuse Treatment Facility” means a facility: (a) in New York State, which is certified by the Office of Alcoholism and Substance Abuse Services; or (b) in other states, which is accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse, or chemical dependence treatment programs.

Outpatient Chemical Abuse and Chemical Dependence Expense Benefit: We will pay the Usual Reasonable and Customary Charges incurred for up to 60 visits during any one calendar year, for the diagnosis and

treatment of Chemical Abuse and Chemical Dependence. Coverage will be limited to facilities in New York State, which are certified by the Office of Alcoholism and Substance Abuse Services as outpatient clinics or medically supervised ambulatory substance programs. In other states, coverage is limited to those facilities, which are accredited by the Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse, or chemical dependence treatment programs. Outpatient Services consisting of consultant or treatment sessions will not be payable unless these services are furnished by a Doctor or Psychotherapist who: (a) is licensed by the state or territory where the person practices; and (b) devotes a substantial part of his or her time treating intoxicated persons, substance abusers, alcohol abusers, or alcoholics. Outpatient coverage includes up to 20 outpatient visits during any one calendar year, for covered family members, even if the Insured Person in need of treatment has not received, or is not receiving treatment for Chemical Dependence and Chemical Abuse provided that the total number of such visits, when combined with those of the Covered Person in need of treatment, do not exceed 60 outpatient visits in any one calendar year, and provided further that the 60 visits shall be reduced only by the number of visits actually utilized by the covered family members..

“Chemical Abuse and Chemical Dependence” means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user’s health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Mammographic Examination Expense Benefit: Benefits will be paid for the following: (a) one Mammogram at any age for an Insured Person who has a prior history of breast cancer or who has a first degree relative with a prior history of breast cancer, upon recommendation of a Doctor; (b) one baseline Mammogram for an Insured Person age thirty-five through thirty-nine; and (c) one Mammogram annually for an Insured Person age forty years or older. We cover such charges the same as any other Sickness

Cytologic Screening Expense Benefit: We cover charges for Expenses incurred for an annual Cytologic Screening (Pap smear) for cervical cancer for women eighteen and older. We treat such charges in the same way as any other Sickness. Cytologic Screening means collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear. Cervical cytology screening also includes an annual pelvic examination.

Chiropractic Care Expense Benefit: We will pay for non-surgical treatment to remove nerve interference and its effects, which is caused by or related to Body Distortion. Body Distortion means structural imbalance, distortion or incomplete or partial dislocation in the human body which: (a) is due to or related to distortion, misalignment or incomplete or partial dislocation of or in the vertebral column; and (b) interferes with the human nerves. We treat such charges in the same as any other Sickness.

Cancer Second Opinion Expense Benefit: We cover charges for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, 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. If this Plan requires the use of Network Providers, the Covered Person is entitled to a second medical opinion from a non-participating specialist, at no additional cost beyond that which the Covered Person would have paid for services from a participating specialist, provided the attending Doctor provides a written referral. A second medical opinion provided by a non-participating specialist absent a written referral will be covered subject to the payment of additional coinsurance. We treat such charges the same way as any other Sickness.

Reconstructive Breast Surgery Expense Benefit: We cover charges for inpatient hospital care for a Covered Person undergoing: (a) a lumpectomy or a lymph node dissection for the treatment of breast cancer; or (b) a mastectomy which is covered under this Plan. Coverage is limited to a time frame determined by Doctor to be medically appropriate.

We also cover charges for breast reconstruction surgery after a mastectomy including: (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 symmetry. Surgery and reconstruction will be provided in a manner determined by the attending Doctor to be appropriate. We treat such charges the same as any other Sickness.

Diagnostic Screening For Prostatic Cancer Expense

Benefit: We cover charges for Diagnostic Screening for Prostatic Cancer 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 prostate-specific antigen test for men: (1) age fifty and over who are asymptomatic; and (2) age forty and over with a family history of prostate cancer or other prostate cancer risk factors. We treat such charges the same as any other Sickness.

Diabetes Treatment Expense Benefit: We cover charges for the following Medically Necessary diabetes equipment services and supplies for the treatment of diabetes, when recommended by a Doctor or other licensed health care provider. We treat such charges the same as any other Sickness. Such supplies include: blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar.

We also cover charges for expenses incurred for diabetes self-management education. Coverage for self-management education and education relating to diet shall be limited to Medically Necessary visits upon the diagnosis of diabetes, where a Doctor diagnoses a significant change in the Insured Person's symptoms or conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Doctor or other licensed healthcare provider, the Doctor's office staff, as part of an office visit, or by a certified diabetes nurse educator, certified nutritionist, certified dietician registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

Enteral Formulas Expense Benefit: We will pay for enteral formulas when prescribed by a Doctor or licensed health care provider. The prescribing Doctor or health care provider must issue a written order stating that the enteral formula is Medically Necessary and has been proven as a disease-specific treatment for those individuals who are or will become malnourished or suffer from disorders, which if left untreated will cause chronic physical disability, mental retardation or death.

We cover enteral formulas and food products required for persons with inherited diseases of amino acid and organic acid metabolism, Crohn's Disease, gastroesophageal reflux with failure to thrive, disorders of the gastrointestinal motility such a chronic intestinal pseudo-obstruction and multiple, severe food allergies which if left untreated will cause malnourishment, chronic physical disability, mental retardation or death. We also cover modified solid food products that are low protein or which contain Medically Necessary modified protein in an amount not to exceed \$2,500 per calendar year or for any continuous period of twelve months.

Maternity Expense Benefit: We will pay benefits for maternity care, including hospital, surgical and medical care. We treat such charges in the same as any other Sickness.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a healthcare facility. Covered services may be provided by a certified-nurse midwife, under qualified medical direction, affiliated or practicing in conjunction with a licensed facility, unless the attending Doctor, in consultation with the mother, makes a decision for an earlier discharge from the Hospital. If so, We will cover charges for one home health care visit. The visit must be requested within 48 hours of the delivery (96 hours in the case of a cesarean section) and the services must be delivered within 24 hours: (a) after discharge; or b) of the time of the mother's request, whichever is later. Charges for the home health care visit are not subject to any deductible, coinsurance or co-payments. Covered Charges include at least two payments, at reasonable intervals, for prenatal care and one payment for delivery and postnatal care provided. We also cover charges for parent education, assistance and training in breast or bottle

feeding and the performance of any necessary maternal and newborn clinical assessments. Newborn infant care is covered when the infant is confined in the hospital and has received continuous hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures, except circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth. Covered services may be provided by a certified nurse-midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

End of Life Care Expense Benefit: If a Covered Person is diagnosed with Advanced Cancer, We will cover services provided by a facility or program specializing in the treatment of terminally ill patients if the Covered Person's attending health care practitioner, in consultation with the medical director of the facility or program determines that the care would appropriately be provided by such a facility or program.

If We disagree with the admission into the facility, or the provision or continuation of care by the facility, We will initiate an expedited external appeal. Until a decision is rendered, We will continue to provide coverage for care provided in the facility. The decision of the external appeal agent will be binding on both Us and the Covered Person.

"Advanced Cancer" means a diagnosis of cancer by the Insured Person's attending health care practitioner certifying that there is no hope of reversal of primary disease and that the person has fewer than sixty days to live. We treat such charges the same way as other Sickness.

Bone Mineral Density Measurements and Tests Expense Benefit: We will pay for Bone Mineral Density Measurements or Tests for the prevention, diagnosis, and treatment of osteoporosis when requested by a health care provider for a Qualified Individual. A Qualified Individual means a Covered Person who meets the following criteria: (1) previously diagnosed as having osteoporosis or having a family history of osteoporosis; (2) symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; (3) on a prescribed drug regimen posing a significant risk of osteoporosis; (4) with lifestyle factors to such a degree as posing a significant risk of osteoporosis; and (5) with age, gender and/or other physiological characteristics which pose a

significant risk for osteoporosis. Coverage includes bone mineral density measurements or tests as covered under the Federal Medicare program as well as those in accordance with the criteria of the National Institute of Health, including dual-energy x-ray absorptiometry. We also cover drugs and devices for bone mineral density that have been approved by the United States Food and Drug Administration or generic equivalents as approved substitutes in accordance with the above criteria. We cover such charges the same as any other Sickness.

Contraceptive Services Expense Benefit: We will pay for Contraceptive Drugs and Devices. Such Drugs and Devices must be approved by the United States Food and Drug Administration and prescribed legally by an authorized health care provider. Covered services are subject to applicable co-payments under the Prescription Drug Benefit Plan.

EXCLUSIONS

The Plan does not cover nor provide benefits for:

1. Expense incurred as the result of dental treatment. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth.
2. Services normally provided without charge by the Canisius College Student Health Center, Infirmary, or Hospital, or by Health Care Providers employed by Canisius College.
3. Eyeglasses, contact lenses, hearing aids, or prescriptions or examinations therefore.
4. Injury due to participation in a riot.
5. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operation by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Injury or Sickness resulting from declared or undeclared war; or any act thereof.
7. Injury or Sickness for which benefits are paid under any Workers Compensation or Occupation Disease Law.
8. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person.
9. Treatment provided in a government hospital unless there is a legal obligation to pay such charges in the

absence of insurance.

10. Elective treatment or elective surgery, except as specifically provided.
11. Cosmetic surgery, except as the result of an Injury occurring while this Plan is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect.
12. Expenses covered by any other medical, health or accident insurance provided on a group basis. This exclusion shall only apply if the entire premium for the coverage under this Plan is paid by the Canisius College, with no contributions from the Insured Student.
13. Injuries sustained as the result of a motor vehicle accident to the extent that benefits are recovered or recoverable under mandatory no-fault benefits insurance.
14. Treatment of mental or nervous disorders except as specifically provided.
15. Treatment of alcohol and substance abuse except as specifically provided.
16. For International Students, expenses incurred within the Insured Person's Home Country or Country of regular domicile.
17. Routine physical, preventive medicines, serums, vaccines, unless prescribed by a Doctor for treatment of an Injury or Sickness covered under this Plan except as specifically provided.
18. Pre-existing conditions as defined in this Plan.
19. For services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature.
20. For expenses as a result of participation in a felony.
21. Suicide, attempted suicide, or intentionally self-inflicted injury.
22. While the Insured Person is intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.
23. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with interscholastic sports, intercollegiate sports, or intercollegiate club sports.

(All students participating in intercollegiate and/or club sports are covered under a separate policy held by the College).

PRE-EXISTING CONDITIONS LIMITATION

A “Pre-existing Condition” is a Sickness, Injury, or related condition for which medical advice, diagnosis; care or treatment was recommended or received by a Doctor during the 6 consecutive months prior to the effective date of the Covered Person’s coverage under this Plan.

We will pay for Covered Medical Expenses in connection with a Covered Person’s pre-existing Injury or Sickness during the first 1 year of coverage, subject to a maximum benefit of \$2,500 per covered Injury or Sickness. The limitation on Pre-existing Conditions will not apply after: (a) a 12 consecutive month period has passed from the Covered Person’s effective date; (b) with respect to a pregnancy, the day after a 10 consecutive month period has passed from the Covered Person’s effective date; or (c) the Covered Person was insured under previous Creditable Coverage within a 63 day consecutive period prior to the effective date of coverage under this Plan. Payment will be made in accordance with the provisions of this Plan.

Continuous Coverage- If a Covered Person is continuously covered under the policy offered through the Policyholder, he/she will be covered for an Injury sustained or Sickness first manifested while so covered. If You enroll for coverage offered through Your Policyholder within 63 days of the end of any preceding company’s policy, You will be considered to have maintained continuous coverage, except for expenses that are the liability of the previous policy. Coverage cannot be considered continuous if a break in enrollment of more than 63 days occurs.

COORDINATION OF BENEFITS

When an Insured Person is covered under more than one valid and collectible health insurance plan benefits payable will be coordinated with the other plan. Reimbursement from all plans will never exceed 100%. A complete description of the Coordination of Benefits provision is included in the Master Policy on file with Canisius College.

APPEALS PROCEDURES

External Appeals Procedure

Under New York State Law, a Covered Person has the right to an External Appeal when health care services are denied by a health insurer on the basis that the services are not Medically Necessary or that the services are Experimental or Investigational.

A “**Final Adverse Determination**” means written notification from the health plan that an otherwise covered health care service has been denied through the plan’s internal appeal procedures.

Eligibility for an External Appeal

To be eligible for an external appeal, a Covered Person or their provider must have received a Final Adverse Determination as a result of the health plan’s internal review/appeal procedures OR the Covered Person and his/her health plan must have agreed to waive the internal appeal procedures.

If services are denied as Experimental or Investigational, the Insured Person must have a life-threatening or disabling condition or disease in order to be eligible for an external appeal AND his/her attending physician must complete and submit an Attending Physician Attestation form.

An external appeal may only be requested if the service or procedure that was denied is a covered benefit under the plan. The external appeal process cannot be used to expand Eligibility coverage under the plan.

For an Expedited External Appeal:

If the attending physician attests that a delay in providing the treatment or service poses an imminent or serious threat to a Covered Person’s health, an expedited appeal may be requested. The request must include an Attending Physician Attestation form.

How to Request An External Appeal:

An external appeal is requested by completing an application form, attaching a check for \$50.00 payable to United States Fire Insurance Company and sending it to the New York State Insurance Department within 45 days of receipt of a notice of Final Adverse Determination or within 45 days of receiving written confirmation from the health plan that the internal appeal procedure has been waived.

Time Frame for Decision

An expedited appeal will be decided by an external appeal agent within three days of receiving a request for an external review from the state.

An external appeal agent will decide a standard appeal within 30 days of receiving the request from the state.

If the external appeal agent overturns the denial, an Insured Person's fee will be refunded.

PRIVACY STATEMENT

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our insureds or former insureds to anyone, except as permitted or required by law. We maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy through your school, or by calling us toll-free at 888-293-9229.

CLAIM PROCEDURES

In the event of an Injury or Sickness:

1. An Insured Student should report at once to the Student Health Center for treatment or advice. If away from the College, secure treatment from your Doctor or from the nearest hospital.
2. A Company claim form is required for filing a claim. Claim forms are available from the Student Health Center or you can download a claim form from:
www.canisius.edu/student_health

Mail the following items to the Claims Administrator at the address below:

- Completed claim form including Insured's name, address, student identification number, and the name of the University under which the student is insured.
 - All itemized medical and hospital bills.
 - Drug bills (not cash register receipts) showing prescription number, name of drug, date prescribed and name of person for whom the drug was prescribed..
3. A claim must be submitted within 90 days after an Injury or Sickness has occurred in order for the claim to be considered.

SEND COMPLETED CLAIM TO:
AmeriBen Solutions (ABS)
P.O. Box 7186
Boise, Idaho 83707
For claim inquiries call: 1-800-953-1801

Claim forms are available in the Student Health Center, Canisius College. The claim forms are also available on the Student Health Center Website at www.canisius.edu/student_health.

REMEMBER THAT EACH INJURY OR SICKNESS IS A SEPARATE CONDITION AND A SEPARATE CLAIM FORM IS REQUIRED.

Conformity with State Statutes means any provision of this Plan which, on its effective date, is in conflict with the statutes of the state in which the Policy is written is hereby amended to conform to the minimum requirement of such statutes.

This brochure is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in the state in which the policy was delivered. Complete details may be found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.