

2009-2010

**STUDENT
ACCIDENT AND SICKNESS
INSURANCE PLAN**

For Domestic Students of:

CANISIUS COLLEGE
2001 Main Street
Buffalo, NY 14208



The Plan is serviced locally by:
M&T Insurance Agency, Inc.
285 Delaware Avenue Suite 4000
Buffalo, NY 14202-1885
716- 853-7960

Policy Number: UCL2842S Form No. CCD09

**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
Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313
1 800-331-1096
www.klais.com

The Plan is serviced locally by

M&T insurance Agency Inc.
285 Delaware Avenue Suite 4000
Buffalo, NY 14202-1885
1 716-853-7960

The Plan is Underwritten By

United States Fire Insurance Company
by: Fairmont Specialty, a Division of
Crum & Forster
Policy No. UCL2842S

PPO Network Provider List

Beech Street

www.beechstreet.com

1.800.432.1776

MultiPlan

www.multiplan.com

1.800.672.2140

**When calling the above toll-free telephone
numbers, please have the name of your
school and the policy number (UCL2842S)
available.**

**TO ALL STUDENTS OF
CANISIUS COLLEGE**

Canisius College recommends that all students enrolled at the College have health insurance coverage. An unexpected illness or injury can result in heavy financial burdens for a student and his/her family. This burden added to the high cost of education may force a student to withdraw from school. Knowing this, Canisius College sponsors a Student Accident and Sickness Insurance Plan designed to help meet student's needs and to enhance retention of students following an illness or injury.

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.

POLICY TERM

The insurance under Canisius College's Student Accident and Sickness Insurance Plan for the Annual Coverage is effective 12:01 a.m. on August 25, 2009. An eligible student's coverage becomes effective on that date or the date the Enrollment Form and full premium are received by the Company or Plan Administrator, whichever is later. The Annual Coverage terminates at 12:01 a.m. on August 25, 2010 or at the end of the period through which the premiums are paid. The Spring Coverage is effective 12:01 a.m. on January 3, 2010, provided the premium is paid, and will terminate at 12:01 a.m. on August 25, 2010.

ELIGIBILITY AND ENROLLMENT

All full-time undergraduate students are automatically covered under the Accidental Death Benefit and the Basic Accident Medical Expense Benefit.

All full-time undergraduate students are eligible to enroll in the Basic Sickness Medical Expense Plan and the Supplemental Accident and Sickness Expense Plan on a voluntary basis. Students may enroll using one of two methods. You may enroll in the Student Accident and Sickness Insurance Plan, via the internet using the Program Administrator's website at: www.ajfusa.com Visa, Mastercard and Discover are acceptable payment methods. The deadline to enroll on line in the Student Accident and Sickness Insurance plan is **September 30, 2009**, for annual enrollment or by **February 7, 2010** for the Spring/Summer semester.

Or you may complete the enrollment form online, print and return the enrollment form with a check or money order to the Plan Administrator, The Allen J. Flood Companies, Inc. at 2 Madison Avenue, Larchmont, NY 10538. **Please note any enrollments submitted after the deadline will be covered from the date after the Plan Administrator receives both the application and premium. Premiums will not be pro-rated.*

All full-time graduate students and part-time undergraduate and graduate students taking at least 6.0 credits are eligible to enroll in the Accidental Death Benefit, the Basic Accident Medical Expense Benefit, the Basic Sickness Medical Expense Benefit and the Supplemental Accident and Sickness Expense Benefit Insurance Plan described in this brochure. Students may enroll using one of two methods. You may enroll in the Student Accident and Sickness Insurance Plan, via the internet using the Program Administrator's website at: www.ajfusa.com Visa, Mastercard and Discover are acceptable payment methods. The deadline to enroll on line in the Student Accident and Sickness Insurance plan is **September 30, 2009**, for annual enrollment or by **February 7, 2010** for the Spring/Summer semester.

Or you may complete the enrollment form online, print and return the enrollment form with a check or money order to the Plan Administrator, The Allen J. Flood Companies, Inc. at 2 Madison Avenue, Larchmont, NY 10538. **Please note any enrollments submitted after the deadline will be covered from the date after the Plan Administrator receives both the application and premium. Premiums will not be pro-rated.*

NOTE: International Students studying on an F-1 Visa are required by Canisius College to purchase a Health Insurance Plan written specifically for International Students. Information about the International Plan is available in the Office of International Student Programs.

Canadian students are eligible to enroll in either the International Plan, noted above, or the plan outlined in this brochure.

LATE ENROLLMENT

Eligible students will be able to enroll after the open enrollment period only if they lose coverage under their parent's plan or employer plan. The student will have to enroll within 63 days in order to avoid a break in

coverage (see Pre-existing Condition Limitation). Proof of such loss of coverage should be submitted to the Plan Administrator, The Allen J. Flood Companies, Inc. along with the completed Enrollment Form and premium. Premiums will not be prorated. The Insured Student will be covered from the date the Enrollment Form and premium are received by the Plan Administrator.

	<u>Premium Rates</u>	
	Annual	Spring/Summer
	(8/25/09 -	(1/03/10 -
	8/25/10)	8/25/10)
Full-time Undergraduate	\$ 710.00	\$ 409.00
Full-time Graduate	\$ 856.00	\$ 494.00
Part-time Undergraduate	\$ 856.00	\$ 494.00
Part-time Graduate	\$ 856.00	\$ 494.00
Spouse	\$1,487.00	\$1,086.00
Per Child	\$ 958.00	\$ 650.00

Part-time student means a student taking 6.0 to 11.5 credits.

IDENTIFICATION CARDS

The Student Identification Card should be picked up at the **Student Health Center**. 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.

DEPENDENT COVERAGE

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; 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 may enroll in the Student Accident and Sickness Insurance Plan, via the internet using the Program Administrator's website at: www.ajfusa.com. You must have the 2009-2010 school year policy number in order to register and obtain a user name and password. Visa, Mastercard and Discover are acceptable payment methods. The deadline to enroll online is **September 30, 2009**, for annual enrollment or by **February 7, 2010** for the Spring/Summer semester.

You may also enroll by completing the enrollment form located in the back of the brochure. Mail the fully completed form with a check for the premium due to: The Allen J. Flood Companies, Inc., Two Madison Avenue, Larchmont, NY 10538**Please note any enrollments submitted after the deadline will be covered from the date after the Plan Administrator receives both the application and premium. Premiums will not be pro-rated.*

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. Requests should be made to the Plan Administrator, The Allen J. Flood Companies, Inc. at the address on the back of the brochure. Premium received by the Company is fully earned upon receipt. **No other requests for a refund of premium will be considered.**

DEFINITIONS

Accident means a specific unforeseen event, which happens while the Insured Person is covered under this Plan and which directly, and from no other cause results in an Injury.

Biologically Based Mental Illness means a mental, nervous, or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the illness. Such biologically based mental illnesses are defined as schizophrenia/psychotic disorders, major depression, bipolar disorder, delusional disorders, panic disorder, obsessive compulsive disorder, bulimia, and anorexia.

Covered Expense means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Plan is in force as to the Insured Person.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state or residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

Injury means bodily injury caused by an Accident, which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student and his or her covered Dependent(s) while insured under this Plan.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Plan.

Loss means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan.

Medical Emergency means Sudden onset of an Injury or Sickness which arises out of a medical or behavioral condition which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain,

that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy; or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

“Medically Necessary” means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided.

A service, drug or supply shall be considered “needed” if it: is ordered by a licensed Doctor; and is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it was ordered.

A service, drug or supply shall not be considered as Medically Necessary if it is investigational, experimental, or educational.

Mental, Nervous or Emotional Disorders means those conditions listed in the standard nomenclature of the American Psychiatric Association.

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.

Serious Emotional Disturbances of a Child means a diagnosis of attention deficit disorder, disruptive behavior disorder, or pervasive development disorder, and where one or more of the following: (a) serious suicidal symptoms or other life threatening self destructive behaviors; (b) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors); (c) behavior caused by emotional disturbances that placed the child at

risk of causing permanent injury or significant property damage; or (d) behavior caused by emotional disturbances that placed the child at substantial risk of removal from the household for a person under the age of eighteen years.

Sickness means sickness or disease, which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

You, Your or Yours means the Insured Student.

We, Us or Our means United States Fire Insurance Company.

PREFERRED PROVIDER NETWORK

Utilizing the Beech Street or Multiplan Nationwide Preferred Provider Network may decrease the Insured Person's out of pocket costs under this Accident and Sickness Insurance Plan. The Beech Street and Multiplan 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. Insured Persons are not required to utilize Beech Street or Multiplan Providers. In order to use the services of a participating provider, the Insured Person must present their United States Fire Insurance Company Medical Identification Card. Identification cards are available at the Student Health Center.

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.

An Insured Person may contact Multiplan at 1-800-672-2140, 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.multiplan.com.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH BENEFIT

If an Insured Person's Injury results in loss of life within 365 days after the covered Accident, the Principal Sum of \$5,000 will be payable.

**BASIC ACCIDENT
MEDICAL EXPENSE BENEFIT**

If as a result of a covered Injury, an Insured Person incurs covered medical Expenses, We will pay 100% of the Covered Expenses incurred within 52 weeks from the date of the Accident up to an Aggregate Maximum of \$3,000 per covered Injury. The following Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) ambulance; (m) durable medical equipment, prosthetic appliances and orthotic devices; and (n) other expenses incurred for the treatment of an Injury.

BASIC SICKNESS MEDICAL EXPENSE BENEFIT

If as the result of covered Sickness, an Insured Person incurs covered medical Expenses, We will pay 100% of the Covered Expenses incurred, as allocated below, within 52 weeks from the date of the first medical treatment of the Sickness up to a maximum of \$2,000 per covered Sickness. This Plan does not cover Expenses for voluntary or elective termination of pregnancy.

Hospital Room and Board Expense Benefit: If an Insured Person requires confinement in a hospital, We will pay the Covered Expenses incurred up to \$250.00 per day.

Intensive Care/Cardiac Care Room and Board Expense Benefit: If an Insured Person requires confinement in an intensive care or cardiac care unit at a hospital, We will pay the Covered Expenses incurred up to \$500.00 per day.

Miscellaneous Hospital Expense Benefit: If an Insured Person incurs Expenses during a hospital confinement or day surgery on an outpatient basis, We will pay the Covered Expenses incurred up to a maximum of \$1,000 per Sickness. Such Expenses include: (a) anesthesia, anesthesia supplies and services; (b) operating, delivery and treatment rooms and equipment; (c) diagnostic x-ray and laboratory tests; (d) lab studies; (e) oxygen tent; (f) blood and blood services; (g) prescribed drugs and medicines; (h) medical and surgical dressings, supplies, casts and splints; (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; (j)

chemotherapy treatment with radioactive substances; (k) intravenous injections and solutions, and their administration; (l) physical and occupational therapy; and (m) other necessary and prescribed hospital expenses.

Surgical Expense Benefit (Inpatient or Outpatient):

We will pay the Covered Expenses incurred up to a maximum of \$2,000 per covered Sickness for surgery performed by a licensed Doctor (In or Out of the Hospital).

In-Hospital Doctor's Fees Benefit: If an Insured Person, who is confined as a resident bed-patient in a hospital, requires the services of a Doctor, We will pay the Covered Expenses incurred up to \$50.00 per visit, limited to one visit per day.

Consultant Expense Benefit (Inpatient and Outpatient):

If an Insured Person requires the service of a Consultant or Specialist when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming or determining a diagnosis, We will pay the Covered Expenses incurred up to a maximum of \$75.00 per covered Sickness.

Licensed Nurse Expense Benefit:

If an Insured Person requires the services of a licensed registered nurse or licensed practical nurse during a hospital confinement, We will pay the Covered Expenses incurred up to a maximum of \$75.00 per day.

Outpatient Doctor Visit Expense Benefit:

If an Insured Person requires the services of a Doctor, We will pay the Covered Expenses incurred up to a maximum of \$50.00 for the first office visit, after a \$5 copay, thereafter, benefits will be payable for the Covered Expenses incurred up to \$35.00 per visit, after a \$5 copay, for a maximum of 2 additional visits per covered Sickness.

Nutritionist Expense Benefit:

If an Insured Person requires a consultation with a licensed nutritionist, We will pay the Covered Expenses incurred up to maximum of \$75.00 per visit not to exceed a maximum of 2 visits per covered Sickness. The Insured Person must be referred for such consultation by his/her Doctor or the Student Health Center.

Basic Physical Examination Benefit:

If an Insured 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.

Measles, Mumps, Rubella Vaccine Benefit (MMR):

If an Insured 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 \$57 only if services are received at the Student Health Center or referred to a Provider by the Student Health Center.

PPD Skin Test Benefit : If an Insured Student, enrolling at Canisius College for the first time, requires a PPD , We will pay the Covered Expenses incurred up to a maximum of \$25 only if services are received at the Student Health Center or referred to a Provider by the Student Health Center.

Meningococcal Vaccine Benefit: If an Insured 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.

Tetanus Diphtheria Vaccine Benefit (TD): If an Insured 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 \$40 only if services are received at the Student Health Center or referred to a Provider by the Student Health Center.

Emergency Room Medical Expense Benefit: If an Insured Person requires the use of a hospital emergency room as a result of a Medical Emergency, We will pay the Covered Expenses incurred up to a maximum of \$200.00 per covered Sickness.

Diagnostic X-ray & Laboratory Expense Benefit: If an Insured Person is prescribed by an attending Doctor for diagnostic x-ray and laboratory services on an outpatient basis, We will pay, after a \$10.00 copay per covered Sickness, the Covered Expenses incurred up to a maximum of \$500.00 per covered Sickness.

Outpatient Prescription Drug Expense Benefit: If an Insured Person requires a prescription drug prescribed by a Doctor, We will pay, after a \$5.00 copay per covered Sickness, the Covered Expenses incurred up to a maximum of \$1,000.00 per covered Sickness.

Ambulance Expense Benefit: If an Insured Person requires the use of a community or hospital ambulance for a Medical Emergency, We will pay the Covered Expenses incurred up to a maximum of \$250.00 per trip.

<p style="text-align: center;">SUPPLEMENTAL ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT</p>
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If as a result of an Injury, an Insured Person incurs covered Expenses in excess of the Basic Accident Medical Expense Benefit of \$3,000 per covered Injury, We will pay 80% of Covered Expenses incurred up to an Aggregate Maximum of \$30,000 per covered Injury.

If as a result of a Sickness, an Insured Person incurs covered Expenses in excess of the allocated benefits under the Basic Sickness Medical Expense Benefit, We will pay 80% of the Covered Expenses incurred up to the Aggregate Maximum of \$30,000 per covered Sickness. The Basic Sickness Medical Expense Benefits are subject to a \$2,000 maximum.

Supplemental Accident and Sickness Medical Expense Benefits are payable for the Covered Expenses incurred: (1) within 52 weeks from the date of the Injury ; or (2) within 52 weeks from the date of the first medical treatment of the Sickness; or (3) until the payment of the Aggregate Maximum has been reached, whichever occurs first.

The following Expenses will be paid under the Supplemental Accident and Sickness Expense Benefit: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) consultant; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) ambulance; (m) durable medical equipment, prosthetic appliances and orthotic devices; and (n) other Medically Necessary expenses incurred for the treatment of an Injury or Sickness.

Fairmont Specialty Travel Assist Plan

Fairmont Specialty has provided a Travel Assistance Service through Europ Assistance USA (EA) which provides 24 hour services that can help you access emergency assistance when you are traveling 100 or more miles away from home. Europ Assistance USA is there when a crisis strikes to help you obtain the care and attention you need.

Over 850,000 multilingual service professionals stand ready to assist you in 200 countries and territories worldwide.

These services are only eligible for payment or reimbursement if EA is contacted at the time of service and has arranged and/or pre-approved the service. Contact number: (877) 279-1913, www.europassistance-usa.com

Services provided:

Medical Evacuation up to \$50,000, Medical Repatriation up to \$50,000, Return of Dependent Children up to \$5,000, Return of Mortal Remains up to \$10,000, Return of Traveling Companion up to \$5,000. Other additional services including a Nurse Helpline are also available.

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 or eating 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, eating disorders 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.

“Eating Disorder” means conditions such as anorexia nervosa, bulimia and binge eating disorder, identified as such in the ICD-9-CM International Classification of Disease or the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, or other medical and mental health diagnostic references generally accepted for standard use by the medical and mental health fields.

“Comprehensive care centers for eating disorders” or “comprehensive care centers” means a provider-sponsored system of care, organized by either corporate affiliation or clinical association for the common purpose of providing a coordinated, individualized plan of care for an individual with an eating disorder that includes all necessary non-institutional, institutional and practitioner services and treatments, from initial patient screening and evaluation, to treatment, follow-up care and support.

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.

Chemical Abuse and Chemical Dependence Expense Benefit:

Inpatient: If on account of Chemical Abuse or Chemical Dependence, an Insured Person requires inpatient treatment, We will pay for such treatment as follows:

When the Insured Person is confined as an inpatient in a Hospital or a Detoxification Facility, We will pay benefits for detoxification on the same basis as any other Sickness. But, We will not cover more than seven (7) days of active treatment in any one calendar year. When the Insured Person is confined in a hospital or Chemical Abuse Treatment Facility, We will pay benefits for rehabilitation services on the same basis as any other Sickness. But, We will not cover more than 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: If on account of Chemical Abuse or Chemical Dependence, an Insured Person is not hospital confined as an inpatient, We will pay Covered Expenses 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 Insured 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. We treat such charges the same way We treat Covered Expenses for any other covered Sickness.

“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.

Mammography Examination Expense Benefit: We will pay Covered Expenses incurred for a Mammographic

exam. The charges must be incurred while the Insured Person is insured for these benefits. 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 the same way We treat Covered Expenses for any other covered Sickness.

Cytological Screening (PAP Smear) Expense Benefit:

We will pay Expenses incurred for an annual Cytologic Screening (Pap smear) for cervical cancer for women 18 and older. We treat such Expenses in the same way We treat Covered Expenses for any other covered 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 an Insured Person's Covered Expenses 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 way We treat Covered Expenses for any other covered Sickness.

Cancer Second Opinion Expense Benefit: We will pay Expenses incurred 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 Insured Person is entitled to a second medical opinion from a non-participating specialist, at no additional cost beyond that which the Insured Person would have paid for services from a participating specialist, provided the Insured Person's 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 We treat Covered Expenses for any other covered Sickness.

Reconstructive Breast Surgery Expense Benefit: We will pay Expenses incurred for inpatient hospital care for an Insured 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 the Insured Person's Doctor to be medically appropriate.

We also cover Expenses 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 and the Insured Person to be appropriate. We treat such charges the same way We treat any other Covered Expenses for any other covered Sickness.

Diagnostic Screening For Prostatic Cancer Expense Benefit: We will pay Expenses incurred 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 Expenses the same way We treat Covered Expenses for any other covered Sickness.

Diabetes Treatment Expense Benefit: We will pay Expenses incurred 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 Expenses the same way We treat any other Covered Expenses for a Sickness. Such supplies include: lancets and automatic lancing devices; glucose test strips; blood glucose monitors; blood glucose monitors for the visually impaired; control solutions used in blood glucose monitors; diabetes data management systems for management of blood glucose; urine testing products for glucose ketones; oral anti-diabetic agents

used to reduce blood sugar levels; alcohol swabs; syringes; injection aids including insulin drawing up devices for the visually impaired; cartridges for the visually impaired; disposable insulin cartridges and pen cartridges; all insulin preparations; insulin pumps and equipment for the use of the pump including batteries; insulin infusion devices; oral agents for treating hypoglycemia such as glucose tablets and gels; and glucagons for injection to increase blood glucose concentration.

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 re-education 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 an Insured Person's Covered Expenses 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 as 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 12 months. We treat such Expenses the same way We treat Covered Expenses for any other covered Sickness.

Maternity Expense Benefit: We will pay benefits for an Insured Person's Covered Expenses for maternity care, including hospital, surgical and medical care. We treat such charges in the same way We treat Covered Expenses for any other covered Sickness.

We cover Expenses 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 copayments. Covered Expenses include at least two payments, at reasonable intervals, for prenatal care and one payment for delivery and postnatal care provided. We also cover Expenses 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 an Insured 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 Insured Person's attending health care practitioner, in consultation with the medical director of the facility or program determines that the Insured Person's care would appropriately be provided by such a facility or program.

If We disagree with the admission of the Insured Person 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 Insured 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 Expenses the same way We treat Covered Expenses for any other covered Sickness.

Pre-Hospital Medical Emergency Services Expense Benefit: When, by reason of a covered Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay benefits for Covered Expenses incurred in excess of the deductible shown in the Plan of Insurance. Covered Expenses include Pre-Hospital Medical Emergency Services provided by a licensed ambulance service.

As used in this provision, Pre-Hospital Medical Emergency Services means the prompt evaluation and treatment of a Medical Emergency condition, and/or non-airborne transportation of an Insured Person to a Hospital. Reimbursement for non-airborne transportation will be based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in: (1) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured

from home, scene of accident or Medical Emergency to a Hospital or between Hospitals.

Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

Bone Mineral Density Measurements and Tests Expense

Benefit: If by reason of a covered Injury or Sickness, an Insured Person requires Bone Mineral Density Measurements or Tests, We will pay Covered Expenses incurred for such measurements and tests. Individuals obtaining these services must meet the following criteria: (a) previously diagnosed as having osteoporosis or having a family history of osteoporosis; (b) symptoms or conditions indicative of the presence, or the significant risk, of osteoporosis; (c) are on a prescribed drug regimen posing a significant risk of osteoporosis; (d) lifestyle factors to such a degree as posing a significant risk of osteoporosis; and (e) age, gender and/or other physiological characteristics which pose a significant risk for osteoporosis. Coverage includes the detection of osteoporosis, outpatient prescription drugs and devices that have been approved by the federal Food and Drug Administration or generic equivalents as approved substitutes, and dual-energy X-ray absorptiometry.

Contraceptive Services Expense Benefit: We will pay benefits for Contraceptive Drugs and Devices, as well as the generic equivalents as substitutes. Such Drugs and Devices must be federally approved by the Food and Drug Administration and prescribed legally by an authorized health care provider. Covered services are subject to any applicable co-payments under the Prescription Drug Benefit Plan.

Off-Label Prescription Drugs for Cancer Expense

Benefit We will pay expenses incurred for prescription drugs approved by the Food and Drug Administration for the treatment of a particular cancer when used to treat another specified cancer, if the drug is recognized for the treatment of that specified cancer in one of the following reference compendia: 1) the American Medical Association Drug Evaluations; 2) the American Hospital Formulary Service Drug Information; 3) the United States

Pharmacopeia Drug Information; or 4) recommended by review articles or editorial comment in a major peer reviewed professional journal.

We will not pay benefits for any experimental or investigational drugs or any drug that the FDA has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

Early Intervention Services Benefit: Benefits will be payable for Early Intervention Services for children up to three years of age who are disabled or at risk of disability on the same basis as any other Sickness. Benefits paid for Early Intervention will not decrease benefits payable for other conditions

Autism Spectrum Disorder Benefit: Benefits will be payable for an Insured Person's Covered Charges on the same basis as any other Sickness for treatment of Autism Spectrum Disorder. "Autism Spectrum Disorder" means a neurobiological condition that includes autism, Asperger syndrome, Rett's syndrome, or pervasive developmental disorder.

EXCLUSIONS

Insured Person: 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).
24. Mental health benefits or services for individuals who are presently incarcerated, confined or committed to a local correctional facility or a prison, or a custodial facility for youth operated by the Office of Children and Family Services;
25. Mental health benefits or services solely because such services are ordered by a court;
26. Benefits or services deemed cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs.

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 Insured Person's coverage under this Plan.

The Pre-existing Condition Waiting Period is 12 months. Coverage will not be provided for a Pre-existing Condition until the Waiting Period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under this Plan and begins on the Insured Person's effective date. If the Insured Person receives treatment for a service for a Pre-existing Condition: (a) We will not pay benefits for such a condition until: the day after a 12 consecutive month period has passed from the Insured Person's effective date; (b) with respect to a pregnancy, the day after a 10 consecutive month period has passed from the Insured Person's effective date; and (c) We will pay only for Loss or Expense incurred after such 12 consecutive month period or ten (10) consecutive months with respect to pregnancy. A period of Creditable Coverage will be credited if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Payment will be in accordance with the provisions of this Plan.

Exceptions: The Pre-existing Conditions exclusion does not apply to any of the following: (a) genetic information in the absence of a diagnosis of a condition related to such information; (b) a covered newborn dependent child who, as of the last day of the 31-day period beginning with the date of birth, is covered under Creditable Coverage; or (c) a covered adopted dependent child under the age of 18, who, as of the last day of the 31-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage

COORDINATION OF BENEFITS PROVISION

New York State Law permits Coordination of Benefits when an Insured Person is covered under more than one valid and collectible health insurance plan. A complete description of the Coordination of Benefits provision is included in the Master Policy on file with Canisius College.

SUBROGATION

Right to Subrogation: In the event that an Insured Person suffers a covered Injury or Sickness for which another party may be responsible, such as someone injuring the Insured Person in an Accident, and We pay benefits as a result of that Injury or Sickness, We will be subrogated and succeed to the Insured Person's right of recovery against the responsible party to the extent of the benefits We have paid. This means that We have the right independently of the Insured Person to proceed against the responsible party to recover the benefits We paid.

APPEAL PROCEDURE

Internal Appeal

If Your claim is denied, You will be notified of the reason with a description of any additional information necessary to appeal the denial.

If You or Your provider would like additional information or have a complaint concerning the denial, please contact Our Claims Administrator, Klais & Companies, Inc. at 1-800-311.1096. Klais will address concerns and attempt to resolve the complaint. If Klais is unable to resolve the complaint over the phone, You may file a written internal appeal by writing to Klais. Please include Your name, social security number, home address, policy number and any other information or documentation to support the appeal.

The appeal must be submitted within 60 days of the event that resulted in the complaint. Klais will acknowledge Your appeal within 10 working days of receipt or within 72 hours if the appeal involves a life-threatening situation. A decision will be sent to You within 30 days. If there are extraordinary circumstances involved, Klais may take up to an additional 60 days before rendering a decision.

External Appeal

Under New York State Law, You have the right to an External Appeal ONLY when a claim is denied because services are not Medically Necessary or the services are Experimental or Investigational AND You or Your provider must have received a Final Adverse Determination on Your internal appeal OR You and the Plan must have agreed to waive the internal appeal process. A “Final Adverse Determination” means written notification that an otherwise covered health care service has been denied through the internal appeal process.

If a service was denied as Experimental or Investigational, You must have a life-threatening or disabling condition or disease to be eligible for an external appeal AND Your attending physician must submit an Attending Physician Attestation form. An external appeal may only be requested if the denied service is a covered benefit under the plan. Instructions, forms and the fee required for an External Appeal may be found at <http://www.ins.state.ny.us/extappqa.htm>.

You must file an External Appeal within 45 days of receipt of a notice of Final Adverse Determination or within 45 days of receiving notice that the internal appeal procedure has been waived. An expedited external appeal will be decided within 3 days of receiving a request from the state. A standard external appeal will be decided within 30 days of receiving the request from the state.

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 800 331-1096.

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:

Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313
www.klais.com

For claim inquiries call: 1 800-331-1096

Claim forms are available at 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.