Student Accident and Sickness Insurance Plan

“The Policyholder”
Canton, NY 13617

2008-2009

Administrator Policy Number: AMH0067469
Underwriter Reference Number: CAS9710630

Underwritten by:
National Union Fire Insurance Company of Pittsburgh, Pa., (“the Company”)
with its principal place of business in New York, NY
a subsidiary of American International Group, Inc. (AIG)

Please keep this brochure as a general summary of the insurance.

The insurance described in this brochure provides limited benefits only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department.
## SUNY Canton

### Student Accident and Sickness Insurance Plan

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INTRODUCTION
Serious financial problems frequently face some of our students and their parents due to an unexpected Injury or Sickness. In an effort to meet this need, we are offering a Student Accident and Sickness Insurance Plan, which is basic coverage for the student’s typical medical expenses for services not provided by our Health Center.

As permitted by policies adopted by the Board of Trustees of the State University, the College requires that all full-time students must enroll in this insurance program unless proof of comparable coverage is demonstrated. Full-time students, who wish to waive the Student Accident & Sickness Insurance coverage, must logon to Northstar Web to complete the billing process, including waiver forms, at: http://banweb.canton.edu

It is very important that the student be covered by medical insurance. We recommend this coverage as supplemental insurance and as indicated above, it is required where no other insurance is in effect.

While attending SUNY Canton, all students are encouraged to use the SUNY Canton Davis Health Center. The Davis Health Center is well equipped and staffed to handle student health needs.

ELIGIBILITY
All full-time students are included in this insurance plan and the premium for coverage is added to the tuition billing unless proof of comparable coverage is furnished.

Covered Students may enroll their spouse and/or dependent children (unmarried children under age 19). Newborn Children: A child born to a Covered Student is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. However, the Covered Student must enroll the child within 31 days of such birth and pay the required additional premium in order to have coverage for the newborn child continue, beyond such 31 days period.

Eligibility requirements must be met each time a premium is paid to continue coverage. The
Company maintains the right to investigate student status and attendance records to verify that Policy eligibility requirements have been and continue to be met. If the Company discovers that the eligibility requirements have not been or are not being met, its only obligation is refund of premium less any claims paid.

NOTE: Except as noted under Termination or as specifically provided under the Extension of Benefits, Dependent coverage expires concurrently with that of the Covered Student.

Covered Students interested in enrolling their spouse and/or dependent children may contact Marshall & Sterling, Inc. or enroll online at www.maksin.com/canton.shtml.

A student who, initially waived coverage under this Policy but subsequently experiences ineligibility under another comparable plan may elect to enroll for coverage under this Policy within 31 days of the date of ineligibility under another comparable plan.

An eligible student may enroll for coverage for his or her dependents only during a drop/add period or within 31 days of marriage, birth, or adoption.

**EFFECTIVE AND TERMINATION DATES**

The Master Policy becomes effective August 12, 2008 at 12:01 a.m., and it expires August 12, 2009 at 12:01 a.m. Coverage remains in effect during holiday and vacation periods. Coverage must be purchased each semester of attendance. Should a Covered Student graduate or withdraw from the College, the insurance shall remain in effect until the end of the period for which the premium has been paid.

Fall benefits are effective August 12, 2008, 12:01 a.m. or the day after the date on which the enrollment and payment of premium is received, if later, terminating on January 12, 2009, 12:01 a.m. Spring benefits become effective on January 12, 2009, 12:01 a.m. or the day after the date the enrollment and premium payment is made, if later, terminating on August 12, 2009 at 12:01 a.m.

The deadline for either a) enrollment or b) “waiver from coverage” is the close of business day on the fifth day of classes (end of the drop/add period). After this deadline, new enrollments or waivers from coverage will be accepted only with the approval of the College Accountant (or designee) in the Student Services Center, French Hall. To receive consideration for a waiver, the student must complete the waiver form online during the billing process or in writing at the Student Service Center within the drop/add period.

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from college during the drop/add period (1st five class days) in any semester for which coverage is purchased shall not be covered under the Policy and all charges will be cancelled on a student’s account with the College. If this reduction of charge results in a credit balance on the account, a refund will be issued promptly by the College. Students withdrawing following the end of the drop/add period will remain covered under the Policy for that semester only, provided the premium has been paid. No refund will be allowed for any student after the drop/add period. However, if the student is entering active military services, coverage will cease and a pro rata refund of premium will be made upon written request. Other than as stated here, no refunds are available.

**WAIVER DEADLINE**

Full-time students, who wish to waive the Student Accident & Sickness Insurance coverage, must submit the online form through the billing process or request a waiver in writing by the fifth day of class (end of the drop/add period).

**PREMIUM RATES**

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Student Rate $434.00 ...217.00 per semester
Spouse Rate $652.00 ...326.00 per semester
Dependent Rate $652.00 ...326.00 per semester

Please contact Marshall & Sterling, Inc. if you should have questions regarding dependent coverage.
DEFINITIONS

“Accident” means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

“Complications of Pregnancy” means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
- acute nephritis or nephrosis; or
- eclampsia; puerperal infection; or
- RH Factor problems; or
- severe loss of blood requiring transfusion; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.

Not included are (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and pre-eclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

Complications of Pregnancy also include:
- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary or elective abortion.)

“Covered Person” means a Covered Student while coverage under the Policy is in effect and those Dependents with respect to whom a Covered Student is insured.

“Deductible/Deductible Amount” means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

“Doctor” as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (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 of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s immediate family member.

“Eligible Expense” as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while the Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

“Emergency Medical Condition” means a Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care could reasonably be expected to result in any of the following:
- the Covered Person’s life could be in serious jeopardy;
- bodily functions would be seriously impaired;
- a body organ or part would be seriously damaged;
- serious disfigurement;
- serious jeopardy to the health of the fetus.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

“Experimental/Investigational” means a drug, device or medical care or treatment that meets the following:
- the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
- the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
- the drug, device, medical care or treatment or the patient’s informed consent document used with the drug, device, medical care or
treatment was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;
(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

“Hospital” means a facility which meets all of these tests:
(a) it provides in-patient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and major surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: mental or nervous disorders; or substance abuse. The term “Hospital” includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

“Injury” means bodily injury due to an Accident which: (a) results solely, directly and independently of disease, bodily infirmity or any other causes; (b) occurs after the Covered Person’s effective date of coverage; and (c) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

“Medical Necessity/Medically Necessary” means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:
(a) it is provided only as a convenience to the Covered Person or provider; or
(b) it is not the appropriate treatment for the Covered Person’s diagnosis or symptoms; or
(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
(d) it is Experimental/Investigational or for research purposes; or
(e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or
(f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or
(g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
DESCRIPTION OF BENEFITS

SECTION I

BASIC ACCIDENT BENEFITS
When an Injury requires: (a) treatment by a Doctor; (b) Hospital confinement; (c) services of a licensed practical nurse or R.N.; (d) x-ray service; (e) use of an operating room, anesthesia, including the administration thereof, laboratory service; (f) use of an ambulance; (g) use of an ambulatory surgical center or ambulatory medical center; (h) if ordered by a Doctor, prescription medicines, drugs, or any other therapeutic services or supplies; or (i) home health care expenses, the Company will pay Eligible Expenses up to an aggregate maximum of $2,000 per Injury per Policy Year, after satisfying a $50 Deductible for each Injury. This benefit includes coverage for treatment of Injury to sound, natural teeth.

Interscholastic/Intercollegiate Sports Expense:
If a Covered Person requires treatment for an Injury as the result of the practice or play of interscholastic or intercollegiate sports, the Company will pay Eligible Expenses as shown above.

SECTION II

BASIC SICKNESS BENEFITS
When the Covered Person suffers a loss from Sickness, the Company will pay Eligible Expenses up to an aggregate maximum of $2,000 per Sickness per Policy Year. Benefits are allocated as follows:

Pre-Admission Tests Expense:
The Company will pay the hospital Eligible Expenses for use of outpatient facilities as needed for tests before a Covered Person is admitted to the Hospital, provided that: a) tests are required for diagnosis and treatment of the ailment for which the Covered Person is hospitalized; b) a hospital bed and operating room have been reserved before the tests are made; c) Hospital confinement occurs within seven (7) days after the tests; and d) the Covered Person is physically present for tests.

Hospital Room and Board Expense:
When Sickness requires Hospital confinement, the Company will pay the Hospital room and board Expense up to the average semi-private rate, not to exceed $200 per day, up to 30 days.

EXTENSION OF BENEFITS
If the Covered Person is receiving treatment for a Sickness or Injury on the date his or her coverage terminates, Eligible Expenses shall include charges incurred for that Sickness or Injury, but only while they are incurred during the 9 month period following such termination of insurance, subject to the applicable Maximum Amounts of this Policy.

This Extension of Benefits only applies to the Covered Person who is not eligible to continue coverage under the new or renewal Policy issued to the Policyholder. Benefits paid for a covered condition before the termination date and during the Extension of Benefits will not exceed the limits of the Policy.

(h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

“Reasonable and Customary” means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

“Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date.

“Sickness” means disease or illness including related conditions and recurrent symptoms of the Sickness. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered one Sickness.
Voluntary Termination of Pregnancy Expense: The Company will pay the Eligible Expense for the voluntary termination of a pregnancy up to a maximum of $500.

Home Health Care Expense: If, as a result of a covered Sickness, a Covered Person incurs home health care expenses, the Company will pay 75% of such Reasonable and Customary expenses within 12 months from the date of the first home health care visit. Such reimbursement is subject to a per Policy Year Deductible of $50 and the maximum number of covered visits is limited to 40 per Policy Year. Four hours of home health aide service shall be considered as one home care visit.

Hospital Emergency Room Expense: When a Sickness requires the use of an emergency room, including the emergency room Doctor, the Company will pay the Eligible Expense, after satisfying a Deductible of $25, up to a maximum of $200. If the emergency room charges include x-ray and laboratory expenses, the maximum benefit will be increased to $1,000. The Deductible will be waived if the Covered Person is referred by the College Doctor.

Included in this benefit, Eligible Expenses for emergency services if the Covered Person is admitted as an inpatient to the Hospital.

Sickness Dental Expense: When a Sickness requires emergency palliative treatment from a dentist for relief of pain, the Company will pay the Eligible Expense up to a maximum of $400 limited to the following: extraction of impacted wisdom teeth $100 per tooth; initial endodontic visit $100; and emergency extractions $100 per tooth.

Outpatient Prescription Drug Expense: When a Sickness requires prescribed medicines, the

Miscellaneous Hospital Expense: The Company will pay the Eligible Expenses incurred during a Hospital confinement or as an outpatient for day surgery for services provided by a Hospital, ambulatory surgical center or ambulatory medical center up to a maximum of $500. Included are: anesthesia, operating room, laboratory tests and x-rays (including professional fees), oxygen, drugs, medicines, dressings, and other necessary non-room and board Hospital expenses.

Surgical Expense: When a Sickness requires surgery, the Company will pay Eligible Expenses based upon the MDR survey of surgical fees valued at the 75th percentile, subject to the maximum surgical benefit of $1,000. Only one surgical procedure will be covered when multiple procedures are performed, unless Medically Necessary.

If the surgery requires the services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed, the Company will pay the Eligible Expense up to a maximum of $250.

If the surgery requires the services of an assistant surgeon, the Company will pay the Eligible Expense up to a maximum of $200.

In-Hospital Doctor’s Fee Expense: If, while confined to a Hospital, the Covered Person requires the services of a Doctor, the Company will pay the Eligible Expense for such services, up to $25 per day, to a maximum of 30 days.

Consultant or Specialist Expense: When a Sickness requires the services of a consultant or specialist, as requested by the attending Doctor, the Company will pay the Eligible Expense up to a maximum of $150.

Outpatient Doctor Fees Expense: When a Sickness requires the services of a Doctor, while not confined to a Hospital, the Company will pay the Eligible Expense up to a maximum of $20 per visit, up to a maximum of 15 visits, beginning with the second visit (beginning with the first visit for students doing internship out of the area, which is more than 100 miles).

Outpatient Diagnostic X-ray and Laboratory Expense: When a Sickness requires diagnostic x-ray, including ultrasound, MRI and CAT Scan, or laboratory services, under the Doctor’s direction, the Company will pay the Eligible Expense up to a maximum of $500 for x-ray, and $300 for laboratory expenses.
Company will pay the Eligible Expense up to a Policy Year maximum of $500, after a $10 per prescription co-pay. However obtained, all Outpatient Prescription Drugs are subject to the Outpatient Prescription Drug Maximum. Coverage includes Expenses for any prescribed drug or device that is FDA approved as a contraceptive or generic equivalents approved as substitutes or for outpatient services such as consultations, examinations, procedures and medical services related to contraceptive methods, insertion or removal and Medically Necessary examination associated with the use of such FDA approved contraceptive drug or device.

This plan includes a drug benefit through Express Scripts for prescription services throughout the United States. For a list of participating pharmacies, go to www.expressscripts.com or call toll-free 1-800-451-6245. An additional benefit to students utilizing Express Scripts pharmacies is the ability to pay only the $10 per prescription co-pay for eligible prescriptions, with any balance directly billed to the claims administrator by the participating pharmacy.

Until your ID card is received, eligible prescriptions will be paid on a reimbursement basis, and a claim form will need to be filed per the standard claim procedures.

Routine Well Women’s Care: After a $10 Co-pay, the Company will pay for routine chlamydia testing at the Student Health Center. When referred by the Student Health Center to an outside provider, the Company will pay for routine chlamydia testing up to $20 after a $10 Co-pay. Routine chlamydia testing is limited to two tests per Policy Year. Routine pap smear is paid as any other Sickness.

SECTION III
SUPPLEMENTAL EXPENSE BENEFIT
If the Eligible Expenses for a Covered Person’s Injury or Sickness exceeds the aggregate maximum the Company paid under the basic Accident or basic Sickness benefits, the Company will pay 80% of the Eligible Expense up to a maximum of $10,000 per Injury or Sickness per Policy Year. Eligible Expenses for daily Hospital room and board will not be more than the average semi-private room charge.

STATE MANDATED BENEFITS
New York Mandates coverage for the following benefits to be paid as any other Sickness:
- Biologically based Mental Illness/Serious Emotional Disturbances
- Breast Cancer Treatment
- Breast Reconstruction
- Clinical Trials Expense
- Outpatient Chemical Abuse and Chemical Dependence
- Mammographic Examination
- Cytologic Screening
- Cancer Second Opinion
- Diagnostic Screening for Prostate Cancer
- Diabetes Treatment
- Enteral Formulas up to $2,500 per Policy Year
- End of Life Care
- Pre-Hospital Medical Emergency Services
- Bone Mineral Density Measurements and Tests
- Contraceptive Services

COORDINATION OF BENEFITS
The Company will coordinate benefits with other health carriers when duplicate coverage exists. Total payment from this coverage and other health coverages under which the Covered Person is enrolled shall not exceed 100% of the Reasonable and Customary Charges for covered services.

CONFORMITY WITH STATE STATUTES
Any provision of this plan of insurance which, on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of such statutes.

Any Expense not specifically listed in the preceding sections is not covered.

EXCLUSIONS
The Policy does not cover nor provide benefits for Loss or Expenses incurred:
1. as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth or as provided elsewhere in the Policy.
2. for services normally provided without charge by the Policyholder’s Health Service/Center, Infirmary or Hospital, or by health care providers employed by the Policyholder.
3. for eye examinations, eyeglasses, contact lenses, replacement of eyeglasses or prescription for such.
4. for hearing examinations or hearing aids; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing apart from the disease process.
5. for routine physical examinations, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in the Policy.
6. for preventive treatment, testing, medicines, serums, vaccines, or vitamins except as specifically provided in the Policy.
7. for Elective Treatment or elective surgery.
8. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational. This exclusion will not apply with respect to services rendered as part of a clinical trial as mandated by Section 3221(k)(12) of the New York Insurance Code.
9. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
10. as a result of an 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 operated by a scheduled airline maintaining regular published schedules on a regularly established route.
11. for Injury or Sickness resulting from war or act of war, declared or undeclared.
12. as a result of participation in a felony or riot.
13. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.
14. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
15. as a result of an Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law.
16. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
17. for Injury resulting from the practicing for, participating in interscholastic or inter-collegiate sports in excess of $2,000.
18. for diagnosis, surgical or medical treatment of infertility, including diagnostic tests and procedures, prescription drugs or medication, or any form of assisted conception, including artificial insemination, intra-fallopian transfer or in vitro fertilization.
19. for surgery and/or treatment of weight reduction.
20. for a treatment, service or supply which is not Medically Necessary.
21. for any services rendered by a Covered Person’s immediate family member.
22. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

CLAIM PROCEDURE

To file a claim under the Accident and Sickness Insurance Plan, the Covered Person should:
1. Complete a claim form, which is available online at www.maksin.com/canton.shtml.
2. The claim form must be completed and signed. Attach all itemized medical and Hospital bills.
   Itemized bills must be furnished with the claim form within 90 days from the date of expense.
3. Questions should be referred to Maksin Management Corp or the Student Health Center (if applicable).
4. Preauthorization and precertification of benefits to providers of medical service are not required.

Send claim form and all itemized bills to:

Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647
1-877-775-5430
NON-RENEWABLE ONE-YEAR TERM INSURANCE

The Policy is non-renewable One-Year Term Insurance. Similar coverage may be purchased for the following academic year. It is the Covered Person’s responsibility to maintain continuity of coverage by inquiring about such coverage if he or she has not received the information for the new Policy Year.

Servicing Agent:
Marshall & Sterling, Inc.
103 Executive Drive, Suite 300
New Windsor, NY 12553
845-567-1000

Davis Health Center – 315-386-7333

Submit all Claims or Inquiries to:
Maksin Management Corp
P.O. Box 2647
Camden, NJ 08101-2647
1-877-775-5430

At Maksin Management Corp we value the trust our customers have placed in us. That is why protecting the privacy of your personal information is of paramount importance to us. For more information, please go to our website at www.maksin.com.

This brochure is a brief description of the Student Accident and Sickness Insurance Plan available under policy series S30494NUFIC. The Policy may contain definitions, reductions, limitations, exclusions and termination provisions. Full details of the coverage are contained in the Policy. If there is any conflict between the contents of this document and Policy, the Policy will govern in all cases.