

# BLANKET ACCIDENT AND HEALTH PLAN

*Designed for the students of:*



13 Oak Drive  
Hamilton, NY 13346

2010–2011

Policy # 10200536

Please keep this outline of coverage  
for future reference.

**Following are the essential provisions of this plan. The Master Policy is held by the College and underwritten by Markel Insurance Company.**

## **INTRODUCTION**

Colgate University makes available a Student Accident and Health Insurance Plan specifically designed for students of the University. This plan is underwritten by Markel Insurance Company. Following is an outline of the coverage available under this plan, which is primary and will pay incurred medical Expenses, subject to policy provisions described in this brochure. A copy of the master policy is on file at the Treasurer's office of the University.

## **ELIGIBILITY**

All registered full-time undergraduate students with 12 credit hours or more attending Colgate University are required to participate in this program unless coverage is waived. Proof of other coverage must be presented to waive coverage. Students enrolled in the basic Accident and Sickness plan may also enroll in the Optional Increased Supplemental Limit as well. This benefit is optional. Students who elect to enroll in this option must have purchased the basic plan and submit the enrollment form along with the additional premium to Niagara National Inc. with a postmark date prior to the school's effective date of coverage, August 1, 2010.

## **REFUND PROVISION**

In the event an Insured person leaves school to enter active military service, coverage will cease and a pro rata refund of premium will be made upon request. Other than as stated here, no refunds are available.

## **TERM OF COVERAGE**

The policy for the current year becomes effective on August 1, 2010 at 12:01 a.m. and expires on August 1, 2011 at 12:01 a.m. The policy protects Insured students at Colgate University at home or while traveling, 24 hours a day, worldwide. Coverage remains in effect during holiday and vacation periods. Should an Insured person graduate or withdraw from the institution, the insurance shall remain in effect until the end of the period for which premium has been paid.

## **WAIVER/ENROLLMENT DEADLINE**

As of the Fall 2010 semester, all students must enroll or waive out of the Colgate University Student Accident and Health Plan. You must log onto [www.NiagaraNational.com](http://www.NiagaraNational.com), and follow the directions to enroll or waive by September 10, 2010.

## **ANNUAL COST**

Student.....\$619

## DEFINITIONS

**Accident** means a sudden, unexpected and unintended event which is identifiable and caused solely by an external physical force resulting in Injury to an Insured person. Accident does not include a Loss due to or contributed to by disease or sickness.

**Deductible** means the amount an Insured is required to pay as provided by the applicable coverage under the policy in the event of a Loss.

**Expense** means the Usual and Customary charges for Medically Necessary treatment, service or supplies. Such Expense shall not include any amount not customarily charged to persons without insurance.

**Hospital** means a licensed institution including a tax supported institution of the state which has on the premises, or prearranged access to, medical and surgical facilities. It must maintain permanent facilities for the care of overnight resident patients under the care of a Physician. It must have a Registered Nurse (R.N.) always on duty or call. Confinement in the special wing of a Hospital used primarily as a nursing, rest, convalescent or extended care facility is not confinement in a Hospital, unless such confinement is because of a lack of space in the Hospital's full wing.

**Injury** means bodily harm caused by an Accident which occurs while the policy is in force and is the sole cause of the Loss.

**Insured** means an eligible student or an eligible student's dependent (if dependent coverage is available under the policy).

**Loss** means medical Expense caused by Injury or Sickness and covered by the Policy.

**Medically Necessary** means medical services, supplies or treatment authorized by a Physician to treat an Insured person's bodily Injury or Sickness which are: a) consistent with the symptoms or diagnosis; b) appropriate and accepted according to good medical practice standards; c) not primarily for the convenience of the Insured person, Physician or other providers; and d) consistent with the most appropriate supply or level of services which can safely be provided to the patient.

**Physician** means any practitioner of the healing arts, licensed by the state in which he practices and acting within the scope of his license, including a duly licensed podiatrist, surgeon, osteopath, dentist, chiropractor, optometrist, psychologist, physical therapist, and graduate nurse. Physician shall not include a member of the Insured's immediate family.

**Pre-Existing Condition** means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date of coverage or as to a pregnancy existing on the enrollment date of coverage. A condition will not be considered pre-existing once an Insured has been covered for 12 months following the effective date of coverage for claims not related to pregnancy. A

condition will not be considered pre-existing once an Insured has been covered for ten months following the enrollment date of coverage for claims that are related to pregnancy.

**Sickness** means disease or illness which causes a Loss while the Insured is covered by the policy. In the event 75% of the eligible students of the Policyholder, reaching a minimum of 300 students are insured, then Sickness means illness or disease resulting in Loss covered by the policy. Sickness includes normal pregnancy and complications of pregnancy.

**Usual and Customary Expense** means an Expense which: a) is charged for treatment, supplies or medical services Medically Necessary to treat the Insured's condition; and b) does not exceed the usual level of charges made for similar treatment, supplies or medical services in the locality where the Expense is incurred.

**We, Us or Our** means Markel Insurance Company.

**You, Your or Yours** means the Insured.

### **CONTINUOUS COVERAGE**

In determining whether a pre-existing provision applies to an eligible person, We shall credit the time You were previously covered under a previous health insurance plan or policy or employer provided health benefit arrangement, if the previous coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Such credit shall apply to the extent that the previous coverage was substantially similar to the new coverage. The creditable coverage outlined above means any prior health care coverage as defined in HIPAA which includes group coverage; individual coverage; Medicare; Medicaid; military service related care; Indian health service or tribal organization coverage; state health benefits risk pool; a public program offered under the Federal Employees Health Benefits Program; a public health plan; Peace Corps Act health plan; state children's health programs (S-CHIP); and foreign national health plans.

### **EXTENSION OF BENEFITS**

Extension of Benefits means the coverage provided under the policy ceases on the expiration date. However, if on the expiration date, the Insured is under a Physician's care for a condition covered by the policy, benefits will be extended for the condition for up to 12 months after the expiration date. This Extension of Benefits only applies to the Insureds who are not eligible to continue coverage under the new or renewal policy issued to the Policyholder. Benefits paid for a covered condition before the expiration date and during the Extension of Benefits will not exceed the limits of the policy.

# DESCRIPTION OF BENEFITS

## BASIC ACCIDENT & SICKNESS BENEFITS:

When You suffer a Loss from an Injury or Sickness, We will pay 80% of the Expense incurred up to an aggregate maximum of \$30,000 after a \$25 per Accident Deductible or a \$50 per Sickness Deductible. The Deductibles will be waived if referred by the Student Health Center. If referred by the Student Health Center to an off-campus facility claim form must be stamped by the Student Health Center to waive any otherwise applicable Deductible. 100% of Usual and Customary charges incurred for the first \$1,000 of the basic Accident Benefits then 80% thereafter. Benefits are allocated as follows:

**Hospital Room and Board Expense:** When Your Injury or Sickness requires Hospital confinement, We will pay the Hospital room and board Expense up to the semi-private rate.

**Hospital Miscellaneous Expense:** We will pay the Expenses incurred by You 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 benefit. We will pay for anesthesia, operating room, laboratory tests, x-rays, oxygen, drugs, medicines, dressings, and other necessary non-room and board Expenses.

**Surgical Expense:** When Your Injury or Sickness requires surgery, We will pay the Expense based on the MDR (Medical Data Research) survey of surgical fees valued at the 90th percentile, subject to the maximum surgical benefit. Only one surgical procedure will be covered when multiple procedures are performed, unless Medically Necessary.

**Anesthetist Expense:** If the surgery requires the services of an anesthetist who is not employed or retained by the Hospital in which the surgery is performed, We will pay the Loss incurred up to a maximum benefit.

**Assistant Surgeon Expense:** If the surgery requires the services of an assistant surgeon, We will pay the Loss incurred up to a maximum benefit.

**In-Hospital Physician's Fees Expense:** If, while confined to a Hospital, Your Injury or Sickness requires the services of a Physician, We will pay the Expense for such services, to a maximum benefit.

**Consultant or Specialist Expense:** When Your Injury or Sickness requires the services of a consultant or specialist, as requested by the attending Physician, We will pay the Expense up to a maximum benefit.

**In-Patient Psychiatric Expense:** If, while confined to a Hospital, You require the services of a licensed psychiatrist, licensed psychologist, or certified clinical social worker, We will pay the Expense. Benefits are limited to one visit per day. Such benefits will be limited to 30 days of active treatment in any policy year.

**Outpatient Physician Fees Expense:** If you require the services of a Physician, while not confined to a Hospital, We will pay the Expense up to the maximum benefit.

**Ambulance Expense:** When Your Injury or Sickness requires the use of an ambulance or air ambulance, We will pay the Expense up to a maximum benefit.

**Voluntary Termination of Pregnancy Expense:** We will pay 100% of the usual and customary expense for the voluntary termination of Your pregnancy up to a maximum of \$300.

**Outpatient Expense:** When Your Injury or Sickness requires the use of outpatient facilities for the use of diagnostic x-ray, including ultrasound, MRI and CAT Scan, laboratory services, and emergency room, under the Physician's direction. We will pay the expense up to a maximum benefit.

**Outpatient Psychiatric Expense:** If, while not confined to a Hospital, You require the services of a licensed psychiatrist, licensed psychologist, or certified clinical social worker. We will pay the Expense. Such Benefits will be limited to 20 visits in any policy year.

**Outpatient Prescribed Medicines Expense:** When Your Injury or Sickness requires prescribed medicines, We will pay 100% of the expense up to an annual maximum of \$400. This shall not exclude coverage of any such drug on the basis that such drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the Food and Drug Administration. Provided, however, that such drug must be recognized for treatment of the specific type of cancer for which the drug has been prescribed in established reference compendia. This shall include coverage for Medically Necessary services associated with the administration of the drug to be contraindicated. Coverage includes Expenses for any prescribed drug or device that is FDA approved as a contraceptive or generic equivalents approved as a substitutes or for outpatient services such as consultations, examinations, procedures and medical services related to contraceptive methods.

**Outpatient Physiotherapy:** We will pay 80% of the expense up to a maximum of \$750.

**Durable Medical Equipment and Supplies Expense:** When your Injury requires Durable Medical Equipment and Supplies, We will pay 80% of the Expense.

## **OPTIONAL INCREASED SUPPLEMENTAL LIMIT**

**Eligibility:** This benefit is optional. Students who elect to purchase this option must have purchased the basic plan as well.

**Term of Coverage:** Students who elect to purchase the Increased Supplemental Limit must submit the enrollment form and premium to Niagara National Inc. with a postmark date prior to the school's effective date of coverage, 8/1/10.

**Increased Supplemental Limit:** Coverage is available to registered full time students who elect to purchase it. The additional premium for this coverage is noted on the enrollment form.

If the covered medical Expenses for an Injury or Sickness exceed the policy maximum paid under Policy Number 10200536, Basic benefit of \$30,000, payment will be made for 80% of the remaining covered Accident or Sickness Expenses to a maximum of \$220,000. The combined maximums under the basic plan and Increased Supplemental Limit will not exceed \$250,000. The total benefits payable for all policy terms for which You are enrolled for the Increased Supplemental Limit will not exceed \$250,000 for any one Accident or Sickness. Covered medical Expenses under this benefit will be the same as covered medical Expenses under the basic policy. All other terms and conditions of the basic policy will apply to this benefit as well. Provisions relating to coverage for Pre-Existing Conditions will apply to the Increased Supplemental Limit benefit separately from the basic policy.

## **MANDATED BENEFITS**

**The following benefits are mandated by state regulation. These benefits are provided: 1) to the extent that the type of Expense is covered under the basic policy and 2) at the same payment level as any other Sickness or Injury, unless otherwise stated below.**

**Outpatient Mental, Nervous or Emotional Disorders or Ailments Expense:** We will pay the outpatient Expense for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, including biologically based mental illness for adults and children; and children with serious emotional disturbances, to the same extent as any other Sickness. Coverage includes the services of a licensed

psychiatrist, licensed psychologist, a certified clinical social worker, or a professional corporation or university faculty practice corporation. Such benefits may be limited to not less than 20 visits in any policy year.

“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.

“Children with serious emotional disturbances” means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

- 1) serious suicidal symptoms of other life-threatening self-destructive behaviors;
- 2) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors);
- 3) behavior caused by emotional disturbances that place the child at risk of causing personal injury or significant property damage; or
- 4) behavior caused by emotional disturbance that place the child at substantial risk of removal from the household.

**Inpatient Mental, Nervous or Emotional Disorders or Ailments Expense:** We will pay the inpatient Expense for the diagnosis and treatment of mental, nervous or emotional disorders or ailments, including biologically based mental illness for adults and children; and children with serious emotional disturbances, to the same extent as any other Sickness. Such benefits may be limited to not less than 30 days of active treatment in any policy year. If the Insured requires partial hospitalization, two partial hospitalization days will equal one inpatient day.

“Active treatment” means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.

“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.

“Children with serious emotional disturbances” means persons under the age of eighteen years who have diagnoses of attention deficit disorders, disruptive behavior disorders, or pervasive development disorders, and where there are one or more of the following:

- 5) serious suicidal symptoms or other life-threatening self destructive behaviors;
- 6) significant psychotic symptoms (hallucinations, delusion, bizarre behaviors)
- 7) behavior caused by emotional disturbances that place the child at risk of causing personal Injury or significant property damage; or
- 8) behavior caused by emotional disturbances that place the child at substantial risk of removal from the household.

**Pre-Admission Tests Expense:** We will pay the Hospital Expense for the use of outpatient facilities as needed for tests before an Insured is admitted for surgery, provided that: a) tests are required for diagnosis and treatment of the ailment for which surgery will be done; b) a Hospital bed and operating room have been reserved before the tests are made; c) the surgery is done within seven days after the tests; and d) the Insured is physically present for tests.

**Emergency Medical Expense:** We will pay the emergency medical services Expenses of a Hospital if an Insured is covered for inpatient Hospital Expenses. Emergency medical services means care for a sudden onset of an ailment which could place the Insured’s life in danger if not treated at once. We do not pay such Expenses unless the care is given within: a) 12 hours after the illness begins; or b) 72 hours after an Accident.

**Elective Surgical Second Opinion Expense:** If surgery is recommended, We will pay for a second opinion from a board certified specialist in the field relating to the surgical procedure proposed. Our payment will include the Expense for x-rays and diagnostic tests.

**Home Health Care Expense:** If, as a result of a covered Sickness, an Insured shall incur home health care Expenses. We will pay 75% of such reasonable and customary Expenses incurred within 12 months from the date of the first home health care visit. Such reimbursement is subject to an annual Deductible of \$50 and the maximum number of covered visits is limited to 40. Four hours of home health aide service shall be considered as one home care visit.

**Chemical Abuse or Dependence Outpatient Benefits Expense:** If You or Your dependent, while insured under this provision, incurs Expense for the outpatient treatment provided by an alcoholism or substance abuse treatment facility or an alcoholism or substance abuse treatment program, We will pay the greater of : a) outpatient benefits in the same manner as any other Sickness, but not to exceed: 1) one visit each day for any one Insured person; or 2) 60 visits in any calendar year; or b) outpatient benefits as otherwise provided under the policy for alcohol or substance abuse. Under part a) above, up to 20 of the 60 visits may consist of counseling for insured family members of the Insured person, even if the Insured person does not receive treatment. Such coverage is limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Services and, in other states, to those which are accredited by The Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse or chemical dependence treatment programs.

**Chemical Abuse or Dependence Inpatient Benefits Expense:** If You or Your dependent, while insured under this provision, incurs Expense for diagnosis and treatment, We will pay, consistent with the level of benefits for other diseases covered under the policy: 1) up to seven days of care during any calendar year for active treatment for chemical dependency and 2) up to 30 days of care during any calendar year for rehabilitation services. Such coverage is limited to facilities in New York State which are certified by the Office of Alcoholism and Substance Services and, in other states, to those which are accredited by The Joint Commission on Accreditation of Hospitals as alcoholism, substance abuse or chemical dependence treatment programs. No chemical abuse or dependence inpatient coverage is provided under any supplemental Expense benefits which may be provided under the policy.

**Maternity Inpatient Care Expense:** We will pay the Expense incurred in connection with: a) inpatient hospitalization services for a covered mother and a newborn child for a minimum of 48 hours after an uncomplicated vaginal delivery; and b) 96 hours after delivery by an uncomplicated cesarean section. Such coverage for maternity care shall include the services of a midwife licensed pursuant to Article 140 of the Education Law, practicing consistent with a written agreement pursuant to Section 6951 of the Education Law and affiliated or practicing in conjunction with a facility licensed pursuant to Article 28 of the Public Health Law. Maternity care coverage shall also include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments. The covered mother shall have the option to be discharged earlier than the time periods established in a) or b) above. In such case, the inpatient Hospital coverage must include at least one home care visit which shall be in addition to, rather in lieu of, any home health care coverage available under the policy. The policy will cover the home care visit which may be requested at any time within 48 hours of the time of delivery (96 hours in the case of a cesarean section), and shall be delivered within 24 hours, (i) after discharge, or (ii) of the time of the mother's request, whichever is later. Such home care coverage shall not be subject to Deductibles, coinsurance or copayments.

**Mammography Expense:** We will pay the Expense for mammography screening for occult breast cancer: a) upon the recommendation of a Physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer; b) a single baseline mammogram for covered persons ages 35 through 39, inclusive; and c) an annual mammogram for covered persons ages 40 and older.

**Breast Reconstruction Expense:** We will pay the Expense incurred in connection with breast reconstruction. This shall include reconstruction after a mastectomy for: a) all stages of reconstruction of the breast on which the mastectomy has been performed; and b) surgery and reconstruction of the other breast to produce a symmetrical appearance in a manner determined by the attending Physician and the patient to be appropriate.

**Cervical Cytology Screening Expense:** We will pay the Expense for annual cervical cytology for cervical cancer and its precursor for women ages 18 and older. Cervical cytology screening shall include an annual pelvic examination, collection and preparation of a pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the pap smear.

**Enteral Formulas Expense:** We will pay the Expense incurred for enteral formulas. This shall include coverage for the cost for enteral formulas for home use for which a Physician or other licensed health care provider legally authorized to prescribe, under Title Eight of the Education Law, has issued a written order. Such written order shall state that the enteral formula is clearly Medically Necessary and has been proven effective as a disease specific treatment regimen for those individuals who are or will become malnourished or suffer from disorders, which if left untreated, cause chronic physical disability, mental retardation or death. Specific diseases for which enteral formulas have been proven effective shall include, but are not limited to: a) inherited disease of amino-acid or organic acid metabolism; b) Crohn's Disease; c) gastroesophageal reflux with failure to thrive; d) disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and e) multiple severe food allergies which left untreated will cause malnourishment, chronic physical disability, mental retardation or death. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein which are Medically Necessary, and such coverage for such modified solid food products for any calendar year or for any continuous period of 12 months for any Insured person shall not exceed \$2,500.

**Diabetes Equipment, Supplies and Education Expense:** We will pay the Expense incurred in connection with the following equipment and supplies for the treatment of diabetes, if recommended or prescribed by a Physician or other licensed health care provider legally authorized to prescribe under Title Eight of the Education Law: a) blood glucose monitors; b) blood glucose monitors for the legally blind and visually impaired; c) data management systems; d) test strips for glucose monitors; e) visual reading and urine test strips; f) insulin; g) injection aids; h) cartridges for the legally blind and visually impaired; i) syringes; ii) insulin pumps and appurtenances thereto; k) insulin infusion devices;

and l) oral agents for controlling blood sugar. We will also provide coverage for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including information on proper diets. Such coverage for self-management education and education relating to diet shall be limited to visits Medically Necessary upon the diagnosis of diabetes, where a Physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management, or where reeducation or refresher education is necessary. Such education may be provided by the Physician or other licensed health care provider legally authorized to prescribe under Title Eight of the Education Law, or their staff as part of an office visit for diabetes or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian upon referral of a Physician or other licensed health care provider legally authorized to prescribe under Title Eight of the Education Law. Education provided by the certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet shall also include home visits when Medically Necessary.

**Mastectomy Care Expense:** We will pay the Expense for coverage for inpatient Hospital care for such period as is determined by the attending Physician, in consultation with the patient, to be medically appropriate for such covered person undergoing a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the policy.

**Clinical Trials Expense:** We will pay the Expense incurred in connection with an Insured's costs in a clinical trial. Clinical trial means a peer-reviewed study plan which has been: 1) reviewed and approved by a qualified institutional review board, and; 2) approved by one of the National Institutes of Health (NIH) or NIH cooperative group or an NIH center; or the Food and Drug Administration in the form of an investigational new drug exemption; or the Federal Department of Veteran Affairs; or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH Institutes for center support grants; or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

**Prostate Cancer Expense:** We will pay the Expense for 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 an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

**Bone Density Measurements and Testing Expense:** We will pay the Expense for bone density measurements and testing when the Insured person meets the eligibility criteria under the Medicare program or those set by the National Institutes of Health (NIH) for the detection of osteoporosis. We will cover the Expense for drugs and devices when the policy has prescription drug and/or durable medical equipment coverage. Qualified Insured persons must have at a minimum: a) a previous diagnosis or family history of osteoporosis; or b) symptoms or conditions indicative of the presence or significant risk of osteoporosis; or c) on a prescribed drug regimen posing a significant risk of osteoporosis; or d) lifestyle factors posing a significant risk of osteoporosis; or e) age, gender and/or physiological characteristics which pose a significant risk of osteoporosis.

**Pre-Hospital Emergency Medical Services Expense:** We will pay the Expense for pre-hospital emergency medical services for the treatment of an emergency condition when such services are provided by an ambulance service.

**Investigational/Experimental Expense:** We will pay the Expense for a health care service, rendered or proposed to be rendered to an Insured on the basis that such service is experimental or investigational, is rendered as part of a clinical trial or a prescribed pharmaceutical product, provided that coverage of the patient costs of such service has been recommended for the Insured by an external appeal agent upon an appeal. The determination of the external appeal agent shall be binding.

**Autism Spectrum Disorder Expense:** We will pay the Expense incurred for the diagnosis and treatment of an autism spectrum disorder. “Autism spectrum disorder” means a neurobiological condition that includes autism, Asperger syndrome, Rett’s syndrome, or pervasive developmental disorder.

## **TRAVEL BENEFITS**

All services or benefits provided in this policy and outlined below must be pre-approved by Us or Our representative.

## **EMERGENCY EVACUATION BENEFIT**

We will pay for Covered Emergency Evacuation Expenses incurred if the Insured person suffers an Injury or Sickness that requires Emergency Evacuation while on Covered Travel. Benefits payable are subject to a maximum amount per Insured person of \$50,000 for all Emergency Evacuations due to all Injuries from the same Accident or all Sicknesses from the same or related causes, and this is also the aggregate maximum for all travel benefits including Medically Necessary Transportation and the Repatriation of Remains Benefit and Family Visitation.

The Physician must order the Emergency Evacuation and must certify that the severity of the Insured person’s Injury or emergency Sickness warrants his or her Emergency Evacuation. All Transportation arrangements made for the Emergency Evacuation must be by the most direct and economical conveyance and route possible.

## **MEDICALLY NECESSARY TRANSPORTATION**

If the Insured person is hospitalized for more than five consecutive days following a Covered Emergency Evacuation. We will pay, subject to any limitations stated herein, for Expenses to return the Insured person from the medical facility to which he or she was treated to the insured person’s return destination, less refunds from the Insured person’s unused Transportation tickets. Airfare costs will be economy or first class if the Insured person’s original tickets are first class.

### **Family Visitation Expense**

If the Insured person is unable to travel due to a Covered Emergency Evacuation, We will pay, subject to any limitations stated herein, for Expenses to bring a family member to and from the Hospital or other medical facility where the Insured person is confined, not to exceed the cost of one round-trip economy airfare ticket. The aggregate maximum payable for this benefit is \$1,000.

## **REPATRIATION OF REMAINS BENEFIT**

If the Insured person suffers a covered loss of life while on Covered Travel, We will pay subject to the limitations stated below, for Covered Expenses reasonably incurred to return the Insured person's body to their home country, but not exceeding a maximum per Insured person benefit amount of \$50,000, and this is also the aggregate maximum for all travel benefits including the Emergency Evacuation Benefit and Medically Necessary Transportation and Family Visitation Expense.

**Covered Expenses:** Covered Expenses include, but are not limited to, Expenses incurred in accordance with the applicable international requirements for:

- (1) embalming;
- (2) cremation;
- (3) the most economical coffins or receptacles adequate for Transportation of the remains; and
- (4) Transportation, according to airline tariffs, of the remains by the most direct and economical conveyance and route possible.

Benefits will not be provided for any Expense provided by another party at no cost to the Insured person or already included in the cost of the Covered Travel.

We or Our representative must authorize all Expenses in advance for any travel benefit to be payable.

### **Definitions**

**The following definitions apply to the aforementioned Travel Benefits:**

**Covered Travel** means any travel 100 miles or more from home.

**Covered Emergency Evacuation Expenses** are those for Medically Necessary Transportation, including Usual and Customary medical services and supplies incurred in connection with the Emergency Evacuation of the Insured person. Expenses for Transportation must be: (1) recommended by the attending Physician; and (2) required by the standard regulations of the conveyance transporting the Insured person.

**Emergency Evacuation** means: (1) the Insured person's medical condition warrants immediate Transportation from the place where the Insured person is injured or sick to the nearest Hospital where appropriate medical treatment can be obtained; (2) after being treated at a local Hospital, the Insured person's medical condition warrants Transportation to the United States or Canada (where he or she resides) to obtain further medical treatment or to recover; or (3) both (1) and (2) above.

**Transportation** means any land, sea or air conveyance required to transport the Insured person during an Emergency Evacuation. Transportation includes, but is not limited to, air ambulance, land ambulance and private motor vehicles.

## **COORDINATION OF BENEFITS**

This policy coordinates with other plans under which an individual is covered so that the total benefits available will not exceed 100% of the allowable Expenses. When a claim is made, other valid and collectible group insurance pays its benefits without regard to this policy. This policy then adjusts benefits so that the total benefits available will not exceed the allowable Expenses. No plan pays more than it would without

the coordination provision. In the absence of other valid and collectible group insurance, it is Our intention that Expenses incurred in connection with any covered Injury or Sickness shall be fully payable subject to the terms, conditions and limitations of this policy.

"Other valid and collectible group insurance" shall mean any plan providing medical Expense benefits for or by reason of dental, Physician, nurse, Hospital care, treatment, or confinement, or the performance of surgery and/or anesthesia, which benefits are provided by (1) any type of service plan contracts, any group or blanket insurance, employee benefit plan or any plan arranged through an employer, trustee, union or employee benefit association; or (2) any plan or program created or administered by national or state government, or agencies thereof. We will not limit or exclude payment on a claim because the Insured person is eligible for or is provided medical assistance under the provisions of Title XIX of the Social Security Act. A plan without a coordinating provision is always the primary plan.

### **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 Loss nor provide benefits for:**

- A. Expenses for dental treatment, except for treatment resulting from Injury to natural teeth; or as specifically provided by a Sickness Dental Expense Benefit, if included in the policy;
- B. Services normally provided without charge by the Policyholder's health service, infirmary, Hospital, or employees;
- C. Routine eye exams and contacts; replacing eyeglasses or prescriptions, therefor; routine examinations and services related to hearing examinations or hearing aids; or treatment for hearing defects not related to an Injury or Sickness;
- D. Routine physical examinations; preventive care; elective surgery and elective treatment; services solely to improve appearance; for personal hygiene; services specifically for dietary control; custodial, sanitarial or rest care; or fertility testing;
- E. Cosmetic surgery. Cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect. A determination that the surgery is cosmetic is a medical necessity determination subject to utilization review and external appeal requirements of titles I and II of article 49 of the Insurance Law (See 11NYCRR 56);
- F. Injury for which mandatory automobile no-fault benefits are recovered or recoverable;
- G. Any Loss or portion thereof, for which benefits are provided under this contract which is not recovered or recoverable from mandatory no-fault insurance because such Loss exceeds the maximum provided under such mandatory no-fault insurance, shall be paid

without regard to the Deductible or coinsurance provisions set forth in the contract;

- H. Any Loss or portion thereof, for which benefits are provided under this contract which is not recovered or recoverable from mandatory no-fault insurance because of a no-fault Deductible shall be paid subject to the Deductible and coinsurance provision set forth in this contract;
- I. Aviation, other than as a fare-paying passenger on a scheduled or charter flight operation by a scheduled airline, and other related activities such as skydiving; recreational parachuting; hang gliding; glider flying; parasailing; sail planing;
- J. Injury or Sickness resulting from any declared or undeclared war;
- K. Injury due to participation in a riot or felony;
- L. Suicide, attempted suicide or intentionally self-inflicted Injury;
- M. Injury or Sickness while in the armed forces of any country. When an Insured enters such armed forces, We will refund the unearned pro rata premium to the Insured;
- N. Injury or Sickness covered by any workers' compensation or occupational disease law;
- O. Treatment provided in a government Hospital, unless the Insured is legally obligated to pay such charges;
- P. Injury resulting from the practice or play of interscholastic and club sports, under the basic Accident benefits, in excess of \$1,000
- Q. Pre-Existing Conditions means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date of coverage or as to a pregnancy existing on the enrollment date of coverage. A condition will not be considered pre-existing once an Insured has been covered for 12 months following the enrollment date of coverage. A condition will not be considered pre-existing once an Insured has been covered for ten months following the enrollment date of coverage for claims that are related to pregnancy. In the event 75% of the eligible students of the Policyholder, reaching a minimum of 300 students are insured, the pre-existing conditions will not apply.

## **Claim Procedure**

To file a claim under the Accident and Health Plan, the student should:

1. Complete a claim form, if applicable, and submit it to the Claims Administrator. Claim forms must be completed and signed for accident claims. A claim form is not required for sickness claims, although in certain circumstances one may be requested by the Claims Administrator for completion. Claim forms are available from the Claims Administrator or online at Our website [www. MarkelAH.com](http://www.MarkelAH.com).
2. Submit itemized medical and Hospital bills within 90 days from the date of loss to the Claim Administrator. Please indicate in your submission, the student's school name, student name, policy number and student ID number even if the charges are for a spouse or dependent.
3. Preauthorization and precertification of benefits to providers of medical service are not required nor provided by Us.
4. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator.

# INCREASED SUPPLEMENTAL LIMIT ENROLLMENT FORM

## 2010 - 2011

School Name: **Colgate University** Student Name: \_\_\_\_\_

Student Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School ID #: \_\_\_\_\_

\$472. for students age 25 and under (8/1/10 - 8/1/11)     \$315. for students age 25 and under (1/1/11 - 8/1/11)

\$714. for students over 25 (8/1/10 - 8/1/11)     \$476. for students over 25 (1/1/11 - 8/1/11)

**This completed form and payment must be received by us prior to : 8/1/10**

Make check or money order payable to:

I hereby certify that as the full-time student applicant named above, the information contained on this enrollment form is true. I understand that the effective date of this coverage under the Increased Supplemental Limit is the same as under my basic plan.

**Niagara National, Inc.**

Mail to:

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Niagara National, Inc.  
5001 Genesee Street  
Buffalo, NY 14225**

**IMPORTANT:** Injury resulting from the practice or play of intercollegiate sports is excluded from this plan.

### **Markel Privacy Practices**

We maintain physical, electronic and procedural safeguards that comply with federal standards to protect Your personal information. We do not use or disclose Your information for any fundraising, marketing or research activities.

We use and disclose Your information to determine Your eligibility for plan benefits, to facilitate payment for treatment and services provided to You, to coordinate benefits and to carry out other necessary insurance-related activities. We use or disclose the minimum information necessary to process a claim or answer a claims inquiry. We may also disclose Your information to law or government agencies when required by law to do so.

Under the privacy laws, You have unlimited access to Your information. You may limit how We use and disclose Your information and get a listing of instances where it was disclosed. You may request that We correct inaccurate information or add missing information.

If You have any questions about Your rights, Our Privacy Practices or You want to file a complaint, please contact Our Privacy Officer at:

**Phone (800) 431-1270 or [www.MarkelAH.com](http://www.MarkelAH.com).**

### **The Plan is Underwritten by:**



**MARKEL INSURANCE COMPANY  
GLEN ALLEN, VIRGINIA 23060**

### **The Plan is administered by:**



**NIAGARA NATIONAL INC.**  
INSURANCE GROUP

5001 Genesee Street, Buffalo, New York 14225

716.684.6000 800.444.5530 f 716.684.6285

niagaranational.com EMAIL: [nninfo@niagaranational.com](mailto:nninfo@niagaranational.com)



### **Mail claims to:**

Co-ordinated Benefit Plans  
A Markel Business Partner  
PO Box 24322  
Tampa, FL 33632-4322

Telephone number 877-794-6908

Fax number 727-499-7884

Email claims to: [claims@cbpinsure.com](mailto:claims@cbpinsure.com)

### **IMPORTANT**

THIS OUTLINE OF COVERAGE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. A COPY OF THE MASTER POLICY IS ON FILE AT THE INSTITUTION.