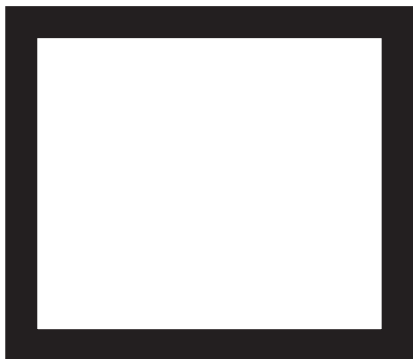


On Your Own, But Not Alone...

Blanket Accident and Health Continuation Plan

*Designed Especially for Students
currently covered by
Markel Insurance Company*



2009–2010



Please keep this outline of coverage
for future reference

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.

Niagara National, Inc. has developed the Student Post-Grad Health Insurance Plan to provide affordable, short-term coverage to meet the needs of new college graduates. This insurance plan is designed to cover the alumnus while seeking employment or until permanent health insurance is secured.

WHO IS ELIGIBLE FOR COVERAGE?

This plan is available to students graduating from a New York Undergraduate or Graduate institution that is insured by Markel Insurance Company. The institution must endorse this program in order for the graduating student to participate. Spouses and dependents of graduating students are not eligible unless they separately meet all of the enrollment requirements. Contact Niagara National, Inc. to discuss dependent eligibility and to obtain a dependent enrollment form.

WHEN CAN I ENROLL?

An alumnus may enroll in the plan anytime within 30 days from the Markel Insurance Company plan in which they were enrolled. They shall have a 30 day grace period for payment of premiums between continuous enrollment periods.

HOW CAN I ENROLL IN THE PLAN?

To enroll in the plan, complete all information requested on the attached enrollment form and return it to Niagara National, Inc. along with the full premium due. Premium may be paid by check, money order, Mastercard, Visa or Discover.

WHEN DOES MY COVERAGE BEGIN?

Coverage becomes effective on one of two dates:

- 1) For those alumni whose insurance terminates upon graduation.
- 2) For those alumni covered by a student insurance plan that terminates at the end of the summer following graduation.

In any event, coverage will not be in effect until a properly completed application and full premium payment are received at the offices of Niagara National, Inc.

WHAT WILL I RECEIVE WHEN I ENROLL?

Upon enrollment in the plan, You will receive a kit which contains an identification card, claim forms and information on how to use the plan, file a claim, etc.

HOW LONG AM I COVERED FOR?

The plan is renewable on a quarterly basis, not to exceed six (6) calendar quarters. After six (6) calendar quarters, the plan is non-renewable.

Once enrolled, You will receive renewal invoices for additional calendar quarters. Those paying by MasterCard or Visa have the option, upon authorization, to have any additional amounts due automatically billed to Your credit card.

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 stated here, no refunds are available.

WHAT IS THE COST OF THE PLAN?

(Premium Subject to Future Adjustments)

QUARTERLY CHARGES

Student Only*	\$635.
Dependents:	
Spouse Only	\$926.
Child(ren) Only	\$926.
Spouse and Child(ren).....	\$1852.

***Includes \$18 Administrative Service Charge Per Quarter.**

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 service 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 nine 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.

SECTION I BASIC ACCIDENT & SICKNESS EXPENSE BENEFITS

When You suffer a Loss from Injury or Sickness, We will pay the Expense incurred at 80% up to an aggregate maximum of \$50,000. Benefits are allocated as follows:

DEDUCTIBLE - \$250 annual (per person).

BENEFITS

- A. Hospital Room and Board Expense:** When Your Injury or Sickness requires Hospital confinement, We will pay the Hospital room and board Expense up to 80% of the semi-private or intensive care unit rate.
- B. Hospital Miscellaneous Expense:** We will pay 80% of 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. We will pay for anesthesia, operating room, laboratory tests, x-rays, oxygen, drugs, medicines, dressings, and other necessary non-room and board Expenses.
- C. Surgical Expense:** When Your Injury or Sickness requires surgery, We will pay 80% of the Expense based on the MDR (Medical Data Research) survey of surgical fees valued at the 90th percentile. 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, We will pay 80% of the Loss incurred.
- If the surgery requires the services of an assistant surgeon, We will pay 80% of the Loss incurred.
- D. Elective Surgical - Second Opinion Expense:** If surgery is recommended, We will pay 80% of the Expense up to the maximum of \$150 for a second opinion by a board certified specialist in the field relating to the surgical procedure proposed. Our payment will include the Expense of x-rays and diagnostic tests.
- E. Ambulance Expense:** When Your Injury or Sickness requires the use of an ambulance or air ambulance, We will pay 80% of the Expense up to the maximum of \$200.
- F. 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 up to 80% of the Expense per day.
- G. 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 80% of the Expense up to a maximum of \$250 per Injury or Sickness.

- H. **Outpatient Expense:** When Your Injury or Sickness requires the use of outpatient facilities of a Hospital or Physician's office for the use of diagnostic x-ray, including ultrasound, MRI and CAT Scan, laboratory services, Outpatient Physician, supplies, or an emergency room, under the Physician's direction, We will pay 80% of the Expense up to a maximum of \$2,000.

Non-emergency use of a Hospital emergency room is covered after the Deductible and subject to 50% coinsurance.

- I. **Outpatient Prescribed Medicines Expense:** When Your Injury or Sickness requires prescribed medicines, We will pay 80% of the Expense for generic drugs and 50% of the Expense for non-generic drugs. 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 substitutes or for outpatient services such as consultations, examinations, procedures and medical services related to contraceptive methods.

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 Injury or 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 this 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 aged 35 through 39, inclusive; and c) an annual mammogram for covered persons aged 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 aged 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; j) 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.

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 which, on its effective date, is in conflict with the statutes of the state in which it is issued, it 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 sports;
 - 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. ; or
 - R) Experimental care; care outside the United States; custodial, sanitarial or rest-care or Intro fertilization and artificial insemination services;
 - S) Services mainly rendered for custodial; rehabilitative, occupational therapy, or invitro therapy;
 - T) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;
 - U) Non-medical self-care or self-help training and all outpatient rehabilitative therapy including but not limited to speech, occupational, recreational, educational dance and art therapy;

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 claims. Claim forms are available from the Claims Administrator or online at Our website, 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.

2009-2010 APPLICATION FOR ENROLLMENT IN CONTINUATION MEDICAL INSURANCE

Instructions: Please complete all information (Print or type).

Detach and mail to Niagara National, Inc., 5001 Genesee Street, Buffalo, New York 14225

Call 1-800-444-5530 if you need assistance completing the application.

Alumnus of _____

Graduation Year _____

PART 1. PERSONAL INFORMATION

Name _____ Daytime Phone _____

Mailing Address _____ Home Phone _____

_____ Date of Birth _____

City _____ State _____ Zip _____ SS# _____

PART 2. BILLING INFORMATION (Quarterly Amounts)

Student Only \$635.** \$ _____

Dependents: (Contact Niagara National for Dependent Enrollment Form)

Spouse Add: \$926. \$ _____

Child(ren) Add: \$926. \$ _____

Spouse + Child(ren) Add: \$1852. \$ _____

**Includes a \$18 administrative Service Charge

Totals \$ _____

(SEE NEXT PAGE)

PART 3. PAYMENT INFORMATION

Check or Money Order (Payable to: **Niagara National, Inc.**)

Credit Cards - Automatic Billing Option

MasterCard[®] or Visa[®] Discover[®]

Card # _____ Exp. Date _____

Credit Card Authorization:

If I selected the credit card - automatic billing option, I authorize Niagara National, Inc. to keep my signature on file and to charge the initial and any subsequent payments as they come due, for the amounts necessary to satisfy my obligations under this insurance agreement, to the credit card account that I have indicated above. I understand that this is valid for eighteen months from the date below unless I cancel the authorization through written notice to Niagara National, Inc.

DATE _____ SIGNATURE X _____

Print Name on Credit Card _____

And Address _____

Market 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.



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



Mail claims to:

**Pioneer Administrative Services
A POMCO Company
A Markel Business Partner
PO Box 186
Syracuse, NY 13206**

Telephone number 866-653-2542
Email: studentinfo@pomcogroup.com

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 Niagara National, Inc.