

# **BLANKET ACCIDENT AND HEALTH PLAN**

*Designed for the students of:*



**ROBERTS WESLEYAN COLLEGE**

2301 Westside Drive  
Rochester, New York 14624

**2008–2009**

**Policy #08200193**

**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.

(This is your temporary insurance ID card. Please remove and carry it with you!)

**STUDENT MEDICAL INSURANCE  
I.D. CARD  
ROBERTS WESLEYAN COLLEGE  
Rochester, N.Y. 14624**

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STUDENT'S NAME

Accident Only  Comprehensive

Dependent Coverage: YES  NO

Policy No.: 08200193

Effective: 12:01 AM 8/27/08 (or date premium paid, if later)

Expiring: 12:01 AM 5/15/09 (or 8/27/09 with  
Comprehensive Coverage)

Plan Underwriter: **MARKEL INSURANCE COMPANY**  
Glen Allen, Virginia 23060

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**INTRODUCTION**

Please refer to the College Health History form and/or Required Insurance Information which provides details on enrollment in Sections I and II which follow.

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

**TERM OF COVERAGE**

The plan protects eligible students of Roberts Wesleyan College, at home, at college, or wherever he or she may be, 24 hours a day. Should an Insured student graduate or leave school for any reason, except to enter military service, the coverage will continue in effect until the end of the period for which premium has been paid. (See exclusion for military service.)

1. The policy for the current year becomes effective at 12:01 a.m. on 8/27/08, and expires on 8/27/09 at 12:01 a.m.
2. Section I, Basic Accident Benefits, is **REQUIRED** of all students with more than 7 credit hours. It is in effect during the regular academic year. The academic year is from August 27, 2008 to May 15, 2009.
3. A Comprehensive plan of insurance is **MANDATORY** for students not otherwise covered by medical insurance. It consists of Section II, III and extension of Section I (see Brochure descriptions), extending coverage for all Sections to August 27, 2009.
4. Protection is in effect during all interim vacation periods.
5. Sports activities are covered, except that coverage for interscholastic sports Injuries is limited to the \$3,000 maximum of the College Accident Medical Insurance. The college has a separate program of insurance beyond the

\$3,000 for interscholastic sports Injuries.

6. These insurance coverages provide certain benefits not normally covered by other medical insurance programs.

## **ANNUAL PREMIUM RATES**

Student Annual Rate .....	\$190
Spouse Annual Rate.....	\$323
Dependent Annual Rate.....	\$323

## **ELIGIBILITY**

You are eligible to be an Insured person if You are enrolled at the college. You must apply for this coverage and pay the required fee before Your insurance will take effect. Dependent coverage is also available.

Students enrolled in the basic Accident and Sickness plan may also enroll in the Optional Increased Supplemental Limit as well. Students who elect to enroll in this option must submit the enrollment form and additional premium to Niagara National, Inc. with a postmark date prior to the school's effective date of coverage, August 27, 2008.

**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.

## **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 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**

**SECTION I**

**BASIC ACCIDENT BENEFITS**

When Your Injury requires: (a) treatment by a Physician; (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 ambulatory surgical center or ambulatory medical center; (h) if ordered by Physician, prescription medicines, drugs or any other therapeutic services or supplies, or (i) home health care Expenses, We will pay the Expense incurred up to an aggregate maximum of \$3,000, after a \$25 Deductible Per Condition. This benefit includes coverage for treatment of Injury to natural teeth.

• Note the specific limits and benefit schedules which follow:

**(THROUGH 5/15/09 12:01 AM)  
(Provides Basic Accident Medical Insurance Only)**

- REQUIRED of all students with more than seven credit hours.
- The cost is covered by the Counseling and Med Fee.
- \$25 Deductible applies to all but interscholastic sports Injuries.
- Claims exceeding \$100 are covered only to the extent they are not covered by other insurance.

**ACCIDENTAL DEATH AND  
DISMEMBERMENT BENEFITS**

Accidental Death and Dismemberment Insurance covers You for a Loss as shown below. The Loss must result from an Accident, directly and independently of all other causes. The Accident must take place while You are insured under the policy. Also, the Loss must take place within 52 weeks after the Accident.

The following table shows the amounts We will pay:

<b>For Loss Of</b>	<b>Amount</b>
Life.....	\$1,000
Both hands or both feet or sight of both eyes .....	\$1,000
One hand and one foot.....	\$1,000
One hand and sight of one eye .....	\$1,000
One foot and sight of one eye .....	\$1,000
One hand or one foot or sight of one eye .....	\$500

The most We will pay for all Losses to an Insured as the result of one Accident is \$1,000.

Loss to hands and feet means severance at or above the wrist or ankle joints. Loss of sight means total and irrecoverable loss of sight.

**SECTIONS II (THROUGH 8/27/09 12:01 a.m. with payment at the start of Fall and Spring Semesters)**

**(Comprehensive Accident, Sickness & Supplemental Plan)**

- This insurance is MANDATORY for all students not otherwise covered by medical insurance.
- The College’s Basic Accident Benefits (see Section I) are extended for the period 5/15/09 - 8/27/09.
- The cost of this is NOT covered in the Counseling and Med Fee.
- This program is an ideal SUPPLEMENT to other medical insurance. It is NOT designed to replace a parent’s or

other medical policy.

- A Sickness claim with total medical Expense under \$100 should be submitted to the College's Plan. If Your Expense is over \$100 and You have other medical insurance, You must also file with that company. Payments will be coordinated between the companies involved.

## SECTION II

### BASIC SICKNESS BENEFITS

When You suffer a Loss from Sickness, We will pay the Expense incurred for the Sickness. Benefits are allocated as follows:

**Hospital Room and Board Expense:** When Your Sickness requires Hospital confinement, We will pay the Hospital room and board Expense up to the semi-private rate, not to exceed \$150 per day, up to a maximum of 30 days.

Intensive Care Unit is limited to \$180 per day up to a maximum of 5 days, when Medically Necessary.

**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 of \$650. 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 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 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, We will pay the Loss incurred up to a maximum of \$250.

If the surgery requires the services of an assistant surgeon, We will pay the Loss incurred up to a maximum of \$200.

**In-Hospital Physician's Fees Expense:** If, while confined to a Hospital, Your Sickness requires the services of a Physician, We will pay the Expense for such services, up to \$50 per day, to a maximum of 30 days.

**Consultant or Specialist Expense:** When Your Sickness requires the services of a consultant or specialist, as requested by the attending Physician to confirm or determine a diagnosis, We will pay the Expense up to a maximum of \$60 per Sickness.

**Outpatient Physician Fees Expense:** When Your Sickness requires the services of a Physician, while not confined to a Hospital, We will pay the Expense up to \$50 per visit, maximum 20 visits, beginning with the second visit. A visit to the College Health Service will be considered as the first visit for this benefit. Cervical Cytology Screening Expense shall not be subject to the Deductible.

**Ambulance Expense:** When Your Sickness requires the use of an ambulance or air ambulance, We will pay the Expense up to a maximum of \$150.

**Outpatient Diagnostic X-ray and Laboratory Expense:**

When Your Sickness requires diagnostic x-ray, including ultrasound, or MRI and CAT Scan, under the Physician's direction, We will pay the Expense up to a maximum of \$250. When Your Sickness requires laboratory services, under the Physicians directions, We will pay the Expense up to a maximum of \$200.

**Licensed Nurse Expense:** If, while confined in a Hospital, Your Sickness requires the services of an R.N. or licensed practical nurse, We will pay the Expense up to a maximum of \$64 per day, limited to 30 days.

**Hospital Outpatient Expense:** When Your Sickness requires the use of outpatient facilities of a Hospital for an emergency room, under the Physician's direction, We will pay the Expense up to a maximum of \$150, when referred by the Student Health Center. During the weekend contact campus security.

**Sickness Dental Expense:** When Your Sickness requires treatment for impacted wisdom teeth or dental abscesses, We will pay the Expense up to a maximum of \$75 per tooth.

**Pre-Admission Tests Expense:** We will pay the Hospital Expense for the use of outpatient facilities as needed for tests before You are 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. Our payment will not exceed \$650. Please see "Mandated Benefits" for further details on this coverage.

**Elective Surgical-Second Opinion:** If surgery is recommended, We will pay the Expense up to a maximum of \$75 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. Please see "Mandated Benefits" for further details on this coverage.

**Outpatient Prescribed Medicines Expense:** When Your Sickness requires prescribed medicines, We will pay the Expense up to a maximum of \$50. 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.

### SECTION III

**SUPPLEMENTAL EXPENSE BENEFIT:** If the covered medical Expense for Your Injury or Sickness exceeds the aggregate maximum We owe under the basic Accident or basic Sickness benefits, We will pay 80% of the Expense up to a maximum of \$13,500. Covered Expenses for daily Hospital room and board will not be more than the usual semi-private room charge. The

benefit for Section III is only available if Section II is purchased by the student.

## 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.

**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 for 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; 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 shall mean the following: 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.

**OPTIONAL BENEFITS  
FOR INTERNATIONAL STUDENTS ONLY  
OBTAIN DETAILS AND A SPECIAL ENROLLMENT  
FORM  
AT THE COLLEGE HEALTH SERVICE OFFICE**

**TRAVEL BENEFITS**

All services or benefits provided in this policy and outlined below must be 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 \$5,000 for all Emergency Evacuations due to all Injuries from the same Accident or all Sicknesses from the

same or related causes.

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 5 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.

### **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 \$5,000.

**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.

### **OPTIONAL COVERAGE**

#### **INCREASED SUPPLEMENTAL LIMIT**

**Eligibility:** This benefit is optional. Students who elect to purchase this option must have purchased the basic plan as well. 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 September 27, 2008.

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. See Eligibility Section for details.

If the covered medical Expenses for an Injury or Sickness exceed the maximum paid under the basic Accident or Sickness Policy Number 08200193 and the basic supplemental benefits, payment will be made for 80% of the remaining covered Accident or Sickness Expenses and will not exceed a combined maximum of \$250,000.

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 coverage 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 coverage as well.

Provisions relating to coverage for Pre-Existing Conditions will apply to the Increased Supplemental Limit benefit separately from the basic policy.

### **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. Benefits are payable on an excess of other valid and collectible medical insurance basis when other insurance is involved on claims of \$100.

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 prescription, 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 which results from trauma, infection or other diseases of the involved part: reconstructive surgery because of congenital disease or deformity of a dependent child. Cosmetic surgery due to congenital defects will be covered for newborn children;
- 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. 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;
- M. Injury or Sickness covered by any workers compensation or occupational disease law;
- N. Treatment provided in a government Hospital, unless the Insured is legally obligated to pay such charges;
- O. Injury resulting from the practice or play of interscholastic sports in excess of \$3,000;
- P. 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.
- Q. Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use.

### **Claim Procedure**

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

1. Complete a claim form, which is available online at Our website, [www.markelah.com](http://www.markelah.com).
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 Loss.
3. Questions should be referred to the Claims Administrator or the Student Health Center (if applicable).
4. Preauthorization and precertification of benefits to providers of medical service are not required nor provided by Us.
5. Claim filing procedures and access to Our claim form are available online at Our website: [www.markelah.com](http://www.markelah.com).



**INCREASED SUPPLEMENTAL LIMIT ENROLLMENT FORM**  
**(Additional Cost with enrollment only '08 - '09)**

School Name: **Roberts Wesleyan College** Student Name: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ ID# \_\_\_\_\_

Premium Enclosed: Annual  \$495. for students age 25 and under as of 8/27/08.

Annual  \$745. for students over age 25 as of 8/27/08.

Spring  \$330. for students age 25 and under as of 1/1/09.

Spring  \$497. for students over age 25 as of 1/1/09.

Make check or money order payable  
to:

**Niagara National, Inc.**

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

Mail to:

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

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

**IMPORTANT:** Injury resulting from the practice or play of interscholastic 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).**



**MARKEL  
INSURANCE  
COMPANY**

**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 CLAIMS ADMINISTRATOR:**

POMCO, A Markel Business Partner

P.O. Box 186

Syracuse, NY 13206-0186

Phone number for claims questions: 1-866-834-4765

fax number: 1-315-433-5444

Claims email - [markelstudentinfo@Pomcogroup.com](mailto:markelstudentinfo@Pomcogroup.com)

### **IMPORTANT**

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