



# Blanket Accident and Health Plan

Designed for the Students of:

## **NORTHLAND INTERNATIONAL UNIVERSITY**

Dunbar, WI 54119  
2010-2011

Policy Number: 10200477

Please keep this outline of coverage for future reference

**NORTHLAND INTERNATIONAL  
UNIVERSITY**





# **BLANKET ACCIDENT AND HEALTH INSURANCE PLAN**

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## ELIGIBILITY

All undergraduate students enrolled for a minimum of 3 or more credits and all graduate students are included in this insurance plan and the premium for coverage is added to the tuition billing unless proof of comparable coverage is furnished.

### 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 08/01/2010 at 12:01 a.m. and expires on 08/01/2011 at 12:01 a.m. 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 DEADLINE

If You have proof of comparable insurance and wish to waive coverage, the deadline to waive out of this plan is 09/15/10.

## ANNUAL PREMIUM RATES

Student Annual Rate.....	\$582
Spouse Annual Rate.....	\$1,498
Dependent Annual Rate.....	\$873

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## 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 rearranged 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, graduate nurse, and nurse practitioner. Physician shall not include a member of the Insured's immediate family.

**Pre-Existing Condition** means any condition for which medical advice or treatment was received or recommended within the six months immediately preceding Your effective date of coverage. This exclusion applies for 12 months after Your effective date of coverage. This exclusion does not apply to a pregnancy existing on Your effective date of coverage. 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.

**Sickness** means disease or illness which causes a Loss while the Insured is 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. If there is any question regarding the methodology used in determining Usual and Customary, You may call the Third Party Administrator indicated at the end of this document who will provide a description of the specific methodology.

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

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

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## **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.



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## Description of Benefits

### SECTION I

#### **BASIC ACCIDENT & SICKNESS EXPENSE BENEFITS**

When You suffer a Loss from Injury or Sickness, We will pay the Expense incurred up to a maximum of \$1,000 after a Deductible of \$50. 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 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 the maximum. 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 75% of the Expense based upon 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.

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 Injury or Sickness requires the services of a Physician, We will pay the Expense for such services.

**Ambulance Expense:** When Your Injury or Sickness requires the use of an ambulance or air ambulance, We will pay the Expense

**Licensed Nurse Expense:** If, while confined in a Hospital, Your Injury or Sickness requires the services of an R.N. or licensed practical nurse, We will pay the Expenses.

**Outpatient Expense:** When Your Injury or Sickness requires the use of outpatient facilities of a Hospital for an emergency room, services of a Physician,, diagnostic x-ray, including ultrasound, MRI and CAT Scan, laboratory services, prescribed medicine and supplies, under the Physician's direction, We will pay 80% of the Expense up to a maximum of \$1,000. This includes coverage for drugs used in the treatment of HIV. Coverage is for drugs that satisfy all of the following: a) prescribed by the Insured's Physician for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection; b) approved by the Federal Food and Drug Administration for the treatment of HIV infection or an illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved for the treatment of HIV infection, or an illness or medical condition arising from or related to HIV infection, and that is in, or has completed a phase 3 clinical investigation; and c) if the drug is an investigational new drug described in (b) above, is prescribed and administered in accordance with the treatment protocol approved for the investigational drug.

## SECTION II

### ACCIDENTAL DEATH & 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:

For Loss Of Amount Life.....	\$5,000
Both hands or both feet or sight of both eyes.....	\$5,000
One hand and one foot.....	\$5,000
One hand and sight of one eye.....	\$5,000
One foot and sight of one eye.....	\$5,000
One hand or one foot or sight of one eye.....	\$2,500

The most We will pay for all Losses to an Insured as the result of one Accident is \$5,000.

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.

### SECTION III

#### **SUPPLEMENTAL EXPENSE BENEFIT**


If the covered medical Expense for Your Injury or Sickness exceeds the aggregate maximum We pay under the basic Accident or basic Sickness benefits, We will pay 75% of the Expense up to a maximum of \$30,000. Covered Expenses for daily Hospital room and board will not be more than the usual semi-private room charge.

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#### **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 Nervous and Mental Disorders, Alcoholism and Other Drug Abuse Expense:** If, while not confined to a Hospital, an Insured's Sickness requires the services of a licensed Physician, licensed psychologist, or treatment in an outpatient treatment facility or transitional treatment services, We will pay the Expenses as indicated. Our payment will be at least \$2,000 of services for outpatient services minus any cost-sharing amounts (Deductibles, copayments, or coinsurance) at the level charged under the policy for other outpatient treatment services or the equivalent benefit measured in services rendered (number of days or visits). If the policy does not use cost-sharing, it is at least \$1,800 in equivalent benefits measured in services rendered. Our payment will be at least \$3,000 for transitional treatment minus any cost-sharing amounts (Deductibles, copayments, or coinsurance) at the level charged under the policy for other transitional treatment services or the equivalent benefit measured in services rendered (number of days or visits). If the policy does not use cost-sharing, it is at least \$2,700 for equivalent benefits measured in services rendered. Total coverage for inpatient, outpatient and transitional treatment services shall not exceed \$7,000.



**Skilled Nursing Expense:** Skilled nursing care coverage is provided for 30 days to Insureds who enter a licensed skilled nursing care facility within 24 hours after discharge from a Hospital. Our payment will be limited to: a) the daily rate payable shall not exceed the maximum daily rate established for licensed skilled nursing care facilities by the Department of Health and Social Services; b) skilled nursing care which is certified as Medically Necessary by the attending Physician and is re-certified as Medically Necessary every seven days; and c) the continued treatment for the same medical or surgical condition for which the Insured was being treated in the Hospital.


**Inpatient Nervous and Mental Disorders, Alcoholism and Other Drug Abuse Expense:** We will pay the Expense for inpatient services for the treatment of nervous and mental disorders, alcoholism and other drug abuse problems as follows: Coverage shall include inpatient Hospital and will be subject to exclusions or limitations which are generally applicable to other conditions covered under the policy, up to 30 days confinement in any calendar year. Our payment will be at least \$7,000 for inpatient services minus any cost-sharing amounts (Deductibles, copayments, or coinsurance) at the level charged under the policy for other inpatient treatment services or the equivalent benefit measured in services rendered (number of days or visits). If the policy does not use cost-sharing, it is \$6,300 in equivalent benefits measured in services rendered. Our payment will be at least \$3,000 for transitional treatment minus any cost-sharing amounts (Deductibles, copayments, or coinsurance) at the level charged under the policy for other transitional treatment services or the equivalent benefit measured in services rendered (number of days or visits). If the policy does not use cost-sharing, it is \$2,700 in equivalent benefits measured in services rendered. Total coverage for inpatient, outpatient and transitional treatment services shall not exceed \$7,000.

**Diabetes Equipment, Supplies, Training Expense:** We will pay the Expenses incurred in connection with: a) installation and use of an insulin infusion pump; b) insulin; c) any other medication

**Reconstructive Breast Surgery Expense:** We will pay the Expenses incurred in connection with reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast.

**Mammography Coverage Expense:** We will pay the Expense for low-dose mammography as follows: a) two examinations for women ages 45 to 49 if all of the following are satisfied: 1) each examination by low-dose mammography is performed at the direction of a licensed Physician or a nurse practitioner, except as provided in (c) below; 2) the woman has not had an examination by low-dose mammography within two years before each examination is performed; b) coverage for women age 50 or older for an annual examination by low-dose mammography to screen for the presence of breast cancer, if the examination is performed at the direction of a licensed Physician or a nurse practitioner if (c) below applies; c) an examination by low-dose mammography that is not performed at the direction of a licensed Physician or a nurse practitioner but that is otherwise covered under (a) above if all of the following are satisfied: 1) the woman does not have an assigned or regular Physician or nurse practitioner when the examination is performed; 2) the woman designates a Physician to receive the results of the examination; 3) any examination by low-dose mammography previously obtained by the woman was at the direction of a licensed Physician or nurse practitioner.

**Home Care Expense:** We will pay the Expense for the Usual and Customary fees for home care. The maximum number of visits is 40 visits in any 12-month period. Each visit by a person providing services under a home care plan or evaluating the need for or developing a plan shall be considered as one home care visit. Up to four consecutive hours in a 24-hour period of home health service shall be considered one home care visit. Home Care means care and treatment of an Insured under a plan of care established, approved in writing and reviewed at least every two months by the attending Physician, unless the attending Physician determines that a longer interval between reviews is sufficient and consisting of one or more of the following: a) part-time or intermittent home nursing care by or under the supervision of a registered nurse.; b) part-time or intermittent home health services that are Medically Necessary as part of the home care plan, under the supervision of a registered nurse or medical social worker, which consist solely of caring for the patient; c) physical or occupational therapy or speech-language pathology or respiratory care; d) medical supplies, drugs, and medications prescribed by a Physician and laboratory services by or on behalf of a Hospital, if necessary under the home care plan to the extent such items would be covered under the Policy if the Insured had been hospitalized; e) nutrition counseling provided by or under the supervision of a registered dietitian or certified dietitian, where such services are Medically Necessary as part




of the home care plan; f) the evaluation of the need for the development of a plan, by a registered nurse, Physician extender or medical social worker, for home care when approved or requested by the attending Physician. We will not pay for home care unless the attending Physician certified that: a) hospitalization or confinement in a skilled nursing facility would otherwise be required if home care was not provided; b) necessary care and treatment are not available from members of the Insured's Immediate Family or other persons residing with the Insured without causing undue hardship. "Immediate Family" means the spouse, children, parents, grandparents, brothers, and sisters of the Insured and their spouses; c) the home care services shall be provided or coordinated by a state-licensed or Medicare-certified home health agency or certified rehabilitation agency. If the Insured was hospitalized immediately prior to the commencement of home care, the home care plan shall also be initially approved by the Physician who was the primary provider of services during the hospitalization.

**Lead Poisoning Screening Expense:** We will pay the Expense incurred in connection with blood lead tests for children under six years of age, which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the Department of Health and Family Services.

**Kidney Disease Expense:** We will pay the Expense incurred in connection with Hospital inpatient and outpatient kidney disease treatment, which may be limited to dialysis, transplantation and donor-related services, in an amount not less than the policy maximum, as defined by the Department of Health and Family Services.

**Hospital, Ambulatory Surgery Center and Anesthetics for Dental Care Expense:** Child Wellness Services Expense: We will pay the Expense incurred in connection with child wellness services for covered children from birth through five years of age. "Well Child Services" means the periodic review of a child's physical and emotional status conducted by a Physician or conducted pursuant to a Physician's supervision, but shall not include periodic dental examinations or other dental services. The review shall include a medical history, complete physical examination, developmental assessment, appropriate immunizations, anticipatory guidance for the parent(s) and laboratory testing in keeping with prevailing medical standards.



**Temporomandibular Joint Disorder Expense:** We will pay the Expense incurred in connection with: a) any diagnostic or surgical procedure involving a bone, joint, muscle or tissue for temporomandibular joint disorders; b) Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular joint disorders if all of the following apply: 1) the condition is caused by congenital, developmental or acquired deformity, disease or Injury; 2) the purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction; and 3) under accepted standards of the profession on the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition; and c) the coverage does not include coverage for cosmetic or elective orthodontic care, periodontic care, or general dental care. Diagnostic procedures and Medically Necessary non-surgical treatment for the correction of temporomandibular disorders may not exceed \$1,250 annually.

**Maternity Expense:** We will pay the Expense for maternity care as follows: a) inpatient care for at least 48 hours after a vaginal delivery; and b) inpatient care for at least 96 hours after a cesarean delivery.

**Well Child Immunizations Expense:** We will pay the Expense for well child immunizations for the following: a) diphtheria; b) pertussis; c) tetanus; d) polio; e) measles; f) mumps; g) rubella; h) hemophilus influenza B; i) hepatitis B; and j) varicella.

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## 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 \$10,000 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 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 \$10,000.

**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**

**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.

## **TRAVEL ASSISTANCE SERVICES**

Provided that travel is 100 miles or more from the Insured's primary residence, AXA Assistance USA shall provide or facilitate the following services below on a worldwide basis, where available and whenever possible:

- 1) 24 Hour toll free access worldwide
- 2) Referrals to hospitals, physicians, and specialists
- 3) Guarantee of Medical Expenses
- 4) Medical monitoring
- 5) Emergency prescription transfer

- 6) Emergency cash/bail assistance
- 7) Legal Referrals
- 8) Telephone translation assistance
- 9) Lost document assistance
- 10) General travel assistance

The toll free number for AXA Assistance USA is (888) 735-8473.

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## **COORDINATION OF BENEFITS**

### **(I) Applicability**

(A) This Coordination of Benefits (“COB”) provision applies to This Plan when an Insured or the Insured’s covered dependent has health care coverage under more than one Plan. “Plan” and “This Plan” are defined below.

(B) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan: (i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but (ii) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Section (IV) Effect on the Benefits of This Plan.

### **(II) Definitions**

(A) “Allowable Expense” means a necessary, reasonable and customary item of Expense for health care, when the item of Expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient’s stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

(B) “Claim Determination Period” means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

(C) “Plan” means any of the following which provides benefits or services for, or because of, medical or dental care or treatment: (i) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes payment, group practice or individual practice coverage. It also includes coverage other than school Accident-type coverage; (ii) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(D) “Primary Plan”/ “Secondary Plan.” The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

(E) “This Plan” means the part of the group contract that provides benefits for health care Expenses.

### **(III) Order of Benefit Determination Rules**

(A) General. When there is a basis for a claim under This plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless: (i) the other Plan has rules coordinating its benefits with those of This plan; and (ii) both those rules and This Plan’s rules described in subparagraph (B) require that this Plan’s benefits be determined before those of the other Plan.

(B) Rules. This plan determines its order of benefits using the first of the following rules which applies: **(i) Non-dependent/ Dependent.** The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a dependent of an employee, member or subscriber.

**(ii) Dependent Child/Parents Not Separated or Divorced.** Except as stated in subparagraph (B) (iii), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents": (a) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but (b) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time. However, if the other Plan does not have the rule described in (a), but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in with custody of the child; (b) then, the Plan of the spouse of the parent with the custody of the child; and (c) finally, the Plan of the parent not having custody of the child. Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care Expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to (III) (B) (ii). However, if the specific terms of a court decree state that one of the parents is responsible for the health care Expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge. **(iv) Active/ Inactive Employee.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule (iv) is ignored. Note: If a dependent is a Medicare beneficiary and if, under the Social Security Act of

1965 as amended, Medicare is secondary to the Plan covering the person as a dependent of an active employee, the federal Medicare regulation shall supersede this paragraph (iv).

**(v) Continuation Coverage.** (a) If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits: (i) First, the benefits of a Plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber; (ii) Second, the benefits under the continuation coverage; (iii) If the other Plan does not have the rule described in subparagraph a., and if as a result, the Plans do not agree on the order of benefits, this paragraph (v) is ignored. **(vi) Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan, which covered an employee, member, or subscriber longer are determined before those of the Plan which covered that person for the shorter time. The other Plan shall determine the order of benefits. (iii) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order: (a) first, the Plan of the parent.

#### **(IV) Effect on the Benefits of This Plan**

(A) When This Section Applies. This Section (IV) applies when, in accordance with Section (III) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as “the other plans” in (B).

(B) Reduction in This Plan’s Benefits. The benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period: (i) the benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and (ii) the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

### **(V) Right to Receive and Release Needed**

Information. Markel Insurance Company has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the Insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming benefits under This Plan must give Markel Insurance Company any facts it needs to pay the claim.

### **(VI) Facility of Payment.**

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, Markel Insurance Company may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under This Plan. Markel Insurance Company will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

### **Conformity with State Statutes**

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


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

### **EXCLUSIONS**

**The policy does not cover Loss nor provide benefits for:**

- 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;
- Services normally provided without charge by the Policyholder’s health service, infirmary, Hospital or employees;
- Routine eye exams and contacts; replacing eyeglasses or prescription therefore; routine examinations and services related to hearing examinations or hearing aids; or treatment for hearing defects not related to an Injury or Sickness;

- 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;
- 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;
- False labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; or similar conditions associated with the management of a difficult pregnancy, but not constituting a distinct complication of pregnancy;
- Treatment or supplies for the newborn infant except that required for the treatment of a covered Accident or Sickness;
- Voluntary termination of pregnancy;
- Skydiving; recreational parachuting; hang gliding; glider flying; parasailing; sail planing; bungee jumping; or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
- Injury or Sickness resulting from any declared or undeclared war;
- Injury due to participation in a riot; commission of or attempt to commit a felony;
- Suicide, attempted suicide or intentionally self-inflicted Injury;
- 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;
- Injury or Sickness covered by any workers' compensation or occupational disease law;

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- Injury or Sickness resulting from being under the influence of alcohol or drugs unless taken on a Physician's advice;
  - Treatment provided in a governmental Hospital unless the Insured is legally obligated to pay such charges;
  - Intercollegiate Sports will be paid as any other Accident;
  - Pre-Existing Conditions; or
  - 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, 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.collegeinsurance.com](http://www.collegeinsurance.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.

Co-ordinated Benefit Plans, A Markel Business Partner  
PO Box 24322  
Tampa, FL 33632-4322  
Phone: 877-794-6908  
Fax number: 727-499-7884  
Email claims to: [claims@cbpinsure.com](mailto:claims@cbpinsure.com)

## 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).

## **NORTHLAND INTERNATIONAL UNIVERSITY**

### **HEALTH INSURANCE WAIVER FORM**

#### **2010-2011**

Any undergraduate student registered at Northland International University with three or more semester credit hours and all graduate students with no minimum credit limit are required to be covered under a credible health insurance program\*. This program can be through the student's parents, through an outside policy in the student's name, or through the policy offered at Northland International University. If a student is covered under an outside policy, the waiver form below should be completed and returned to Northland International University. Any student who does not have a completed waiver form on file will be charged for the Basic Plan student insurance offered by Northland International University.

Student's Name: \_\_\_\_\_

of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator.

Co-ordinated Benefit Plans, A Markel Business Partner  
PO Box 24322  
Tampa, FL 33632-4322  
Phone: 877-794-6908  
Fax number: 727-499-7884  
Email claims to: [claims@cbpinsure.com](mailto:claims@cbpinsure.com)

Underwritten by:



Glen Allen, VA 23060

Marketed by:



**Educator Resources / Student Accident**

Subagent - Dale Bear

Phone: (866) 447-6222

Email: [dbear@wiaonline.com](mailto:dbear@wiaonline.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 the institution.